State Advisory Committee on Mental Health Services
February 5, 2009 9:00 am to 4:00 pm
Country Inn and Suites, 5353 No. 27th Street, Lincoln, NE
AGENDA

OPEN MEETING

9:00 AM

1	Welcome and Introductions	Bev Ferguson	Call to order
2	Attendance-Determination of Quorum	Alexandra Castillo	Roll Call
3	Approval of November 4, 2008 Minutes	Bev Ferguson	General Consent
4	Approval of Agenda	Bev Ferguson	General Consent
5	Housekeeping	Jim Harvey	Inform

PUBLIC COMMENT

6 a. Each person wishing to speak at the meeting needs to sign up on the Public Comment Sign-in Sheet. b. Each person will be called on from the Public Comment Sign-in Sheet. Each person may have 5 minutes (unless the chair grants more time) to provide comments. Public comments not provided verbally may be mailed to the Division of Behavioral Health Services, Attention: Alexandra Castillo.

REPORTS

7	Response to Committee Recommendations of November 4, 2008	Scot Adams
8	Nebraska Association on Aging	June Pedersen
9	Discussion on Quality Improvement Framework/Performance Contracting	Sheri Dawson
10	Discussion on Suicide Prevention Initiative in 2010	Jim Harvey

WORKING LUNCH - PRESENTATION

11	Region 3 BH Report	Beth Baxter

UPDATES

12	Legislative Bills	Vicki Maca
13	Update on Children's Behavioral Health	Beth Baxter
14	Children's Behavioral Health Task Force Update	Maya/Beth Baxter
15	Office of Consumer Affairs	Dan Powers
16	PATH (Project for Assistance on Transition from Homelessness)	Jim/Dan Powers
17	MH Committee By-Laws Review	Jim Harvey
18	MH Committee Appointment Terms	Jim Harvey
19	Transformation Transfer Initiative Grant	Jim Harvey
20	Criminal Justice Update	Jim Harvey
21	Consumer Survey Report	Jim Harvey
22	URS Tables Update	Jim Harvey
23	Other - agenda items added at meeting only if an emergency exists	

PUBLIC COMMENT

24	Mental Health Committee Questions/Recommendations to DBHS	ALL
25	Agenda Items for Next Meeting	ALL
26	Plus/Delta	ALL

4:00 PM

27	**ADJOURN**	ALL

The agenda is kept continually current, and is readily available for public inspection at the Division of Behavioral Health during normal business hours. The Division of Behavioral Health is located on the 3rd floor of the Nebraska State Office Building, 301 Centennial Mall South, Lincoln, Nebraska, 68509

State Advisory Committee on Mental Health Services
February 5, 2009 – 9:00 A.M. to 4:00 P.M.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE
DRAFT - MINUTES

Committee Members Present:
Adria Bace, Beth Baxter, Jimmy Burke, Chelsea Chesen, Roxie Cillessen, Pat Compton, Cheryl Crouse, Bev Ferguson, Scot Ford, Dwain Fowler, Chris Hanus, Clint Hawkins, Kathy Lewis, Frank Lloyd, Vicki Maca, Colleen Manthei, Pat Talbott, Dianna Waggoner

Committee Members Absent:
Leslie Byers, Morgan Hecht, ~~Kathy Lewis~~, Jerry McCallum

DBH Staff Present:
Jim Harvey, Dan Powers, Alexandra Castillo, Sheri Dawson

Others Present:
Sarah Briggs, Joe Busby, Barbara Grant, Nancy Kratky, Ed Lankas, June Pedersen, Bryan Reichmath, Kate Speck, Kim Whitaker

I. CALL TO ORDER

Chairperson, Bev Ferguson called the meeting to order at 9:00 a.m.

Roll call determined a quorum was met. 15 out of 21 appointed members were present at the beginning of the meeting. Each member introduced themselves and gave a brief statement about themselves. Susan Krome resigned from the Mental Health Advisory Committee on February 24, 2009.

II. APPROVAL of November 4, 2008 MINUTES

√ Motion was made by Scot Ford and seconded by Colleen Manthei to approve the November 4, 2008 minutes as submitted. Voice vote was unanimous, motion passed.

III. APPROVAL OF AGENDA

√ Motion was made by Jerry McCallum and seconded by Scot Ford to accept the February 5, 2009 agenda as submitted. Voice vote was unanimous, motion passed.

IV. PUBLIC COMMENT

Kate Speck from the Nebraska Children's Behavioral Cultural and Linguistic Competence Work Team, distributed and reviewed information on the State Infrastructure Grant (SIG) Project's Cultural and Linguistic competency. **Attachment 1**

Barbara Grant from the Lincoln Indian Center, spoke of The Indian Center's 3 year SAMHSA Infrastructure Grant/Circle of Care Grant to provide the Urban Indian Community of Lincoln and Omaha with tools and resources to plan/design a community based system of care for mental health and wellness for Indian families. Their mission is to conduct an analysis on existing services provided in these areas and to create a survey to determine what problems exist when accessing services, and to determine service gaps. Behavioral Health (BH) Staff and Committee members offered many resource leads and the Division will also send Ms. Grant resource information.

V. BH DIVISION REPORTS

Response to Committee Recommendations/Questions/Comments

The BH Director, Scot Adams provided the DBH response to the Committee's recommendations dated November 4, 2008. Responses related to: Arbor Program process, Comparison of the

Consumer Survey Youth Data to the Professional Partner's Satisfaction Survey, and the payment process regarding a RentWise trainer. **Attachment 2**

The Committee asked the Division to invite the Arbor Program to the May 7th, Meeting to discuss the Program's screening tools, the rules they use and how flexible they are in supporting the needs of the client.

The Professional Partner Program has a satisfaction survey where the measures can be compared. BH has other sources/measures and BH Staff, Maya Chilese will check into it further and report back at the May 7th meeting.

Nebraska Suicide Prevention Report
Jim Harvey reviewed an inventory of activity in Nebraska related to Suicide Prevention. A list of agencies and contacts was provided to the Committee. **Attachment 3**

The Behavioral Health Director, Scot Adams, wants to create a 2010 goal statement on Suicide Prevention and is seeking input from the Committee.

Suggestion and comments:

- "Nebraska be a top five state in Suicide Prevention"
- Seek the status of lowest suicide rate in the Nation for all age groups.
- Teen suicides in Nebraska are the 2nd cause of death amongst teenagers.
- The choking game amongst teens is on the rise and deaths are listed as suicide but if the police would investigate many could be categorized as accidental.
- University of Nebraska Kearney has a suicide program grant and other colleges may also have similar programs.
- Training staff to recognize persons contemplating suicide and know the levels of handling the suicide.
- Target population by children vs. adults and population such as veterans and homeless.
- Educate consumers.
- To reduce the suicide rate and continue with education and skills training.
- Law enforcement does not have the training and should not be responding to a person in crisis. Law enforcement should not be the transporting agent.
- Expectation for all 6 BH regions to have a capacity in some form to handle crisis.

Nebraska Association on Aging
June Pedersen, Director of the Lincoln Area Agency on Aging, sent a letter on July 23, 2009 to the Division Behavioral Health (DBH) explaining the their concerns with Behavioral Health services. She spoke of the stigma of the older population being labeled "mentally ill", sporadic access to mental health services and problems within the rural areas. **Attachment 4**

The Agency on Aging believes there is a need for Intensive Case Management (IMC) for mental health and would like ICM to be available in all regions.

The Harvest Project in Lincoln, Nebraska is funded by Region 5. The Agency on Aging would like the support to be expanded throughout the State. Individuals must have a Mental Health and/or Substance Abuse diagnosis to get reimbursement for services from Magellan. The program has 3 Intensive Case Managers, each carry a case load of 25 persons for a total of 75 cases. Currently the three collaborating components are: the Agency on Aging, Center Pointe, and the Community Mental Health Program. At this time there is no waiting list. Clients on are on a voluntary basis. Most often the individuals are without family and without support.

The Division plans to have C.J. Johnson, Regional Administrator (RA) from Region 5 share information at the next Network Management Team (NMT) meeting on how they handle the Harvest Project within Region 5.

Continuous Quality Improvement (CQI)
Sheri Dawson stated that CQI will create a more and focused system. The attachments are drafts the Division is using to get feedback and questions. **Attachment 5 & 6**

The Committee members provided the following on What QI mean to individuals?

- When concerns are determined it makes it easier to focus on the problem, to fix the problem and to avoid blaming.
- Get an aim on how to make an improvement.
- Need to get information from the consumer directly.
- What does the QI process cost? And is it really worth it?
- Co-providers see it as a layer of data collecting bureaucracy, hassle/obstruction, and prevents having direct access to consumers.
- The money should be put into action providing services for patients that need it.
- QI will outline show how things are done, will help determine how to improve low performance measures.
- Survey of consumers is the best measure of performance of the quality of services.
- Consider providers reporting, suggest adding money. It's expensive and time consuming to take notes and type entries.
- What does it cost not to do QI? No QI means not improving quality of services.
- Performance measures need to be meaningful in certain areas.
- Accountability is required to access funds. Magellan will give data on the people served but CQI is bigger than that, it looks at services. How reliable is the data? Is training needed to ensure correct data collection?
- To have a QI framework will keep BH accountable and challenge the Division to purchase services that are going to make a difference in people's lives.
- There is pledge constrain of dollars, it is important to provide services in the most cost effective way.
- QI is required to access federal funds and show that a job or services isn't just being done but that it's being done in the best possible way and the service is really needed.
- The Federal Government requires outcomes and if the State can't show outcome there's penalties. There is a great value to adding a CQI component to any system.

The director wants to know DBH is purchasing quality services with providers that are making a difference in people's lives.

Feedback will be used for the 2010 contracts. Send your comments to Sheri Dawson at sheri.dawson@nebraska.gov or Jim Harvey at jim.harvey@nebraska.gov . The considered feedback list will be provided at the May 7th meeting.

Region 3 Behavioral Health Report
Beth Baxter, RA for Region 3 reported on the Behavioral Health Program. Beth reviewed her PowerPoint and the Region's annual report. **Attachment 7**

Region 3 collects data and outcome data for certain services, like children's services. The satisfaction survey looks at the level of satisfaction of the services received, such as reducing symptoms, increasing an individual's ability to function well and their quality of life. The providers are audited for services purchased and financial accountability.

Region 3 went through a system change regarding prevention from funding agencies to funding coalitions. There are 5 prevention coalitions. Coalitions purchase prevention services from prevention agencies within the community. Region 3 has 6 to 8 psychiatrists, 9 people providing peer support, and 3 formalized partnerships with education. They also have a Transition team that focuses on kids. When kids are in the Professional Partnership Program turn17 years of age they are automatically set-up for the adult Transition Program. The Transition Program involves the youth and family.

Beth Baxter will work with other BH Regions to set-up the regional report for the next MHAC meeting.

Legislative Bills
DBH Administrator, Vicki Maca handed out a list of legislative bills with a one line description and the name of the proposing Senator. The Legislative bills related to mental health and the Division are: LB275, LB277, LB346, LB356, LB519, LB540, and LB619 can be viewed online. **Attachment 8**

Update on Children's Behavioral Health (CBH)
Beth Baxter reviewed a chart of children's services funding. The services are listed by Region and by service category. The chart does not show "Youth Transition Program" in other Regions because it was not reported by the other BH Regions. Beth Baxter and Vicki Maca will be contacting the other regions for Youth Transition Program information. **Attachment 9**

Children's Behavioral Health Task Force/Update
Beth Baxter handed out the planning recommendations report from the Division dated November 2008. The handout covers the bulk of the November meeting. The next Task Force meeting is scheduled for February 23, 2009. **Attachment 10**

Office of Consumer Affairs (OCA)
Interim OCA Administrator, Dan Powers reported the 23rd Annual Alternatives conference will be held October 28, 2009 through November 1, 2009 in Omaha, Nebraska. It is a national conference funded by Mental Health Services. It is put together by Mental Health consumers for consumers. The Division will be sponsoring 26 consumers to attend the conference. There will not be a Mental Health consumer conference this year. The consumers will be notified of the Alternatives Conference by the National Conference Alternative persons.. The Office of Consumer Affairs will be sending out scholarship applications to consumers. **Attachment 11**

Regarding OCA Administrator, there were a total of 68 OCA applications. Six applicants were selected to be interviewed and one should be hired by the end of March. Some of the committee's specific requirements for the new OCA Administrator are to demonstrate leadership experience, to demonstrate grant making skills, a willing to learn and continue to grow, to have flexibility, and experience and knowledge of mental health and substance abuse.

Project for Assistance in Transition from Homelessness (PATH) Program
Dan Powers reported PATH is a $300,000 federal grant and has remained at $300,000 for at least 10 years. The current allocations: Region 1 gets $11,333, Region 3 gets $11,333, Region 5 gets $65,000 and Region 6 gets $200,334. Changes will be made to the allocation amounts based on the number of homeless with. Those amounts have not yet been determined.

Jim Harvey referred to the "Voluntary Programmatic Performance Goals" and asked the Committee to review the goals. The goal is to work more closely with the Housing Assistance program and collect PATH data that has not been collected in the past. **Attachment 12**

MH Committee By-Laws Review
DBH reviewed the MHAC By-Laws and determined some terms needed to be updated. The statutes that authorize the committee is on the last page of the By-Laws. The proposed changes were discussed and the suggestions are: **Attachment 13**

Article III, Section 2, will be retained and will read "The Length of Term: As appointed by the Governor"

Article III, Section 3, delete "Chairperson" and add "Division of Behavioral Health" in two places and will delete "Health and Human Services, HHSS" and add "Division of Behavioral Health".

Article V, Section1, delete the word "Selection". The statement "In the event of a vacancy, the committee will elect a member to serve the unexpired term of office" be moved to Article V, Section 3 on page 3.

Article V, Section 3, delete "TERM: No officer shall serve more than three consecutive one year terms." and add "At the fall meeting the committee will select officers for one year. The new officers" term is January 1 through December 31", and add sentence from Article V, Section1, "in the event of a vacancy the Committee will elect a member to serve the unexpired term of office".

Article VI, Section 4, delete the word "Secretarial".

Article VIII-Amendments, second paragraph delete "Administrator of the Behavioral Health Services Division" and replace with "Director of the Division of Behavioral Health" also "Administrator" will be deleted and "Director" will be added.

√ Motion was made by Scot Ford and seconded by Pat Talbott to accept the first proposed changes reviewed by the Committee. Roll call vote was taken and resulted in favor, motion passed.

√ Motion was made by Cheryl Crouse and seconded by Jimmy Burke to have the proposed changes be considered as a draft and to be presented to the Committee at the May 7, 2009 meeting. Voice vote was unanimous and motion passed.

MH Committee Appointment Terms
Committee members appointment list of terms was handed out for review. The individuals with terms ending in July 1, 2009 were contacted by Division staff and all members confirmed their desire to continue as committee members. The Division will inform the Director of the confirmations and they will be forwarded to the Governor's office. There are currently there are 2 vacancies. Applications can be accessed via the Governor website www.gov.state.ne.us/bc/app/pdf. **Attachment 14**

Transformation Transfer Initiative Grant
Jim Harvey announced that the Division received the Transformation Transfer Initiative funds of $221,000. The draft application was reviewed at the last Committee meeting. The MHAC had a genuine impact on the results. The plan will start with a Request For Proposals (RFP) for contractors to do peer support training for peers and family members. The 6 Regional Program Administrators, approved Peer Support Specialist, NAMI, the Mental Health Association and family organizations will be part of the RFP development. A one day statewide meeting will be held in August 2009 to discuss the role of Peer Support Specialists. The actual date and location is not yet determined. The peer support training will start after September 15, 2009. Once there is a contractor, the Division will invite a representative to attend a MHAC meeting.

Suggestions/Questions:
* Will this change the Peer Specialist status? Will it be reimbursable by Medicaid or insurance? No, it will develop a core curriculum for an approved Peer Support Specialist within the state and enable

peer support specialists to move to other locations within Nebraska.
* Committee encourages the Division to contact Larry Fricke for advice relating to peer support training.
* Suggest the Division create a peer support application difficult enough to ensure that peer support applicants can read, write and have a good learning possibility.
* Trainer to go before trainers to ensure they are good trainers.
* Committee asked the Division to send the final TTI Grant to them.

Criminal Justice Update
Jim Harvey stated the Nebraska Justice Behavioral Health Initiative Strategic Plan is now posted on the BH website. **Attachment 15**

Five goals are listed and the plan is to start with Goal #3: Jail Screening. A Jail Standards Conference will be held on April 16, 2009 in Kearney. The Division will make a presentation on Jail Screening and make a formal recommendation to the Jail Standards Board on July 17, 2009 for a standardized statewide jail screening instrument.

Consumer Survey Report
The summary of consumer survey was mailed to the Committee for their review. **Attachment 16** Questions can be directed to Jim Harvey at jim.harvey@nebraska.gov .

URS Tables Update
The URS tables had problems and the problems were resolved. The URS tables were submitted to the Federal Government by the required deadline of December 1, 2008. The current URS tables are posted on the BH website. **Attachment 17**

VI. Public Comment
Cheryl Crouse brought a message from her Psychiatrist. The Psychiatrist is upset because of the Division continues to reduce number of beds at the Lincoln Regional Center. There are people at high risk to themselves and others and they can not get them into LRC. Vicki Maca is willing to discuss concerns directly with Cheryl's Psychiatrist, Susan Howard.

The youth in HRC are not emancipated as adults and they come from YRTC and are still are youths. The HRC youth program is not involving the families. Many of the youths are from Lincoln and Omaha and the Facility should be built closer to Lincoln and Omaha so the families could be involved. In one instance a youth graduated and went home. That same night the youth went home got a gun, was drinking and shot a man. The family was not involved. Family and home environments are not being changed. Cheryl wants this to be addressed to Scot Adams.

VII. Mental Health Advisory Committee Recommendations to BH Division
The Committee did not have any recommendations for the Division.

VIII Agenda Items for next meeting
- Lack of family involvement with HRC youth
- Invite an Arbor Program Representative
- BH possible sources to compares measures
- Update on Children's Behavioral Health
- Children's Behavioral Health Task Force/Update
- By-Law Draft Review
- Office of Consumer Affairs
- Region Report

XI. Plus

Public Comment at the beginning went well.
Public Comment does not warrant a response.
Some member liked "Public Comment" at the end of meeting.
Public Comment will be offered twice for a few more meetings.

Delta

Meeting went too long.
Extend the length of the meeting.
Need less agenda items.

X. Adjournment & Next Meeting

√ Motion was made by Beth Baxter and seconded by Scot Ford to adjourn the meeting. Voice vote was unanimous and motion passed.

Prepared by: Alexandra Castillo, Staff Assistant, DHHS Division of Behavioral Health

Approved by _____ Date 4/22/09
DHHS, Division of Behavioral Health

Attachment 1

NEBRASKA CHILDREN'S BEHAVIORAL HEALTH CULTURAL AND LINQUISTIC COMPETENCE WORK TEAM

PURPOSE: The Cultural and Linguistic Competence Work Team will develop and implement strategies to improve cultural and linguistic competence in the children's behavioral health and related systems

CHARGE:

1. Develop toolkit for providers to include information on using medical interpreters, where/how to locate, and other aspects of providing linguistic access within their clinical setting.
2. Establish protocols for carrying out translations of essential documents and assure translated materials are kept up to date and available
3. Oversee development of a geo-map of consumers and staff by race, ethnicity and language
4. Using regional self assessments completed in 2006, develop and implement a workforce development plan related to cultural competence.
5. If consensus is reached among DHHS leadership, develop standards for contract language related to cultural and linguistic competence.

MEMBERS:

1. Kate Speck - PPC (Facilitator)
2. Laura Watkins – PPC
3. Raponzil Drake – DHHS-MH
4. Macolm Miles – Region 5 BH
5. Brandon Fletcher – Youth Representative
6. Sherri Haber – DHHS – CFS
7. Representative from NATI
8. Federation of Families Representative
9. Dan Powers – DHHS – BH
10. Maria Prentiss- Lintel
11. Jose Soto – Southeast Community College
12. Paula Eurek – DHHS – PH
13. Cathy Johnson – Magellan Family & Consumer Advocate

SIG YEAR 5 STRATEGY 2.7

June 3, 2008

2.7 Incorporate expectations and mechanisms to ensure cultural and linguistic competence across child serving systems.		
CURRENT ACTION STEPS	**COMMENTS**	**FUTURE STEPS**
Obtain technical assistance from the National Center for Cultural Competence pertaining to cultural and linguistic competence.	Vivian Jackson – Georgetown Technical Assistance	Ongoing
DHHS Office of Minority Health curriculum roll out assist will assist to increase diversity on the Steering Committee.	- Committee has briefly reviewed the curriculum; Magellan has a Cultural Competency Resource Kit that is also available including a service system assessment;	Curriculum is nearing completion and SIG subcommittee will look at supplementary materials to support the curriculum -- SAGE Multicultural CD Series; we have identified an organizational assessment that could be used.
Work with the Nebraska Association of Translators and Interpreters to increase access for behavioral health and post information on the behavioral health website for work force access.	- Develop toolkit for providers to include information on using medical interpreters, where/now to locate, and other aspects of providing linguistic access within their clinical setting.	This tool kit would be a part of an overall plan to promote and support cultural and linguist services.
Develop list of documents for translation. Have selected materials translated.	- Define types of materials most essential for translation and conduct inventory of materials meeting that definition. - Develop schema for prioritizing items for translation and the languages for which translation should done. - Establish mechanisms for carrying out translations and assuring that translated materials are kept up to date and available	We are in the process of identifying the documents and translation resources.
Update and implement regional cultural competence tool for regional/organizational self-assessments.	- Using regional self-assessments completed in 2006, develop and implement a workforce development plan related to cultural competence: - Include in plan a series of instructional sessions on cultural/linguistic competence and offer within regions, with CMEs/CEUs provided. - Establish ongoing methods for supporting staff development, such as building on current web site used for perinatal depression and early childhood social/emotional development curricula.	- We have identified an organizational assessment that could be used to assist organizations to periodically review their policies and procedures. - We have identified an organizational assessment that could be used to assist in providing an overview of an organization's needs.

Attachment 2

February 3, 2009

To: Beverly Ferguson, Chair, State Advisory Committee on Mental Health Services

From: Scot L. Adams, Ph.D., Director, Division of Behavioral Health

Re: Division of Behavioral Health Responses to State Advisory Committee on Mental Health Services Questions and Comments from November 4, 2008

On November 4, 2008, the Committee raised the following questions, to which is attached our response:

The Committee Asked: Request the Division to check on the Arbor Program process and if there is an assessment/screening to help the individual.

- Division of Behavioral Health Response – There was discussion about the State's federally mandated 'welfare to work' program for those receiving economic assistance at the last meeting. During this discussion, several questions about the process for participants were raised specifically regarding a screening for BH issues. Employment First has indicated that they do brief screening as it relates to potential barriers and allow opportunity for discussion and disclosure during face to face interview. At that time an individual can discuss family circumstances that may create barriers to work but is also responsible for providing documentation of such issues. There are several exemptions for required work participation such as: pregnancy and post partum, incapacitated due to physical or mental impairment, parent needed at home to care for disabled family member/child, and more. Their brief assessment tool includes questions about safety, mental health, emotional stability and substance abuse, in an attempt to identify potential barriers to work. The original screening tool was created using SAMHSA guidelines. Referral to treatment is made as appropriate. Arbor has more extensive assessment documents as well.

The Committee Asked: Recommend the Division to do a comparison of the Consumer Survey Youth Data to the Professional Partner's Satisfaction Survey.

- Division of Behavioral Health Response – The Consumer Survey is designed to measure a number of things for Federal reporting purposes such as access, general satisfaction, participation in treatment and cultural sensitivity. The Professional Partner program utilizes the Wraparound Fidelity Index that evaluates eleven measures for fidelity. These results for PP are quite high across the state. However, they can not be compared to the Consumer Survey because they measure different elements. The most recent Annual Report for PP is 2007. Currently the Division is performing a closer analysis and evaluation of the PP program and will be able to provide a more comprehensive evaluation report of it after the end of this fiscal cycle.

The Committee Asked: Recommends the Division to investigate a payment process regarding a RentWise Trainer.

- Division of Behavioral Health Response – The Division did investigate the situation. It was found the person did successfully complete the RentWise Train the Trainer program and, afterwards, provided the RentWise training for five persons in August 2008. At the person's request, the Division of Behavioral Health entered into a contract with the Mental Health Association on December 3, 2008 in order to pay the $500. The Division received an invoice on December 23, 2008 which was processed that same day. The $500 payment was paid on January 22, 2009.

January 29, 2009

Attachment 3

To: Scot L. Adams, Ph.D., Director
Division of Behavioral Health
Department of Health and Human Services
From: Jim Harvey
Re: NE Suicide Prevention Report

On November 12, 2008, you requested a **brief report (1-2 pages)** regarding suicide prevention work going on in Nebraska. The report is due by the end of January 2009. In order to prepare this report, I met with representatives from the NE Suicide Prevention Coalition, on November 19, 2008 and January 23, 2009. I also discussed this with Blaine Shaffer.

AN INVENTORY OF ACTIVITY IN NE

- The Nebraska State Suicide Prevention Coalition (NSSPC) – This is a voluntary group made up of committed and passionate people representing public and private agencies, suicide survivors and interested citizens. David Miers and Don Belau are the Co-Chairs (see attached).
- This Coalition prepares one of the annual goals reported in the Federal Community Mental Health Services Block Grant application. ADULT GOAL 3: SUICIDE PREVENTION is used to address the Narrative Question: Adult - A statement of the State's priorities and plans to address unmet needs. The FY2009 edition is attached.
- BryanLGH Foundation – is the keeper of the funds that the Coalition obtains from donations such as the Kim Foundation.
- Kim Foundation grant to the Coalition is for mini grants of $1,000 to $3,000 to local communities.
- Community Health Endowment (Lancaster County) - Grant to support Local Outreach To Suicide Survivor (LOSS) training.
- Boys and Girls Town takes National calls
- Community Mental Health Center of Lancaster County provides a hotline
- Division of Behavioral Health fund the six Regional Behavioral Health Authorities Emergency Services which includes Emergency Protective Custody …
- "Rural Response Hotline"
- Web Resource – General Behavioral Health Tools – Suicide Prevention
  nebhands Resources / University of Nebraska Public Policy Center
  http://www.nebhands.nebraska.edu/ … Includes links to national resources.
- Web Resource – DHHS / Division of Public Health / Suicide Prevention Website
  http://www.dhhs.ne.gov/beh/mh/suialert.htm … Includes links to national resources.
  - IF YOU ARE IN CRISIS PLEASE STOP AND CALL 1-800-784-2433
  - Nebraska State Suicide Prevention Plan - Nebraska's State Suicide Prevention Coalition (NSSPC) embraces the aim and model proposed by the former US Surgeon General, David Satcher, M.D., in the 2001 publication National Strategy for Suicide Prevention: Goals and Objectives for Action.
    - AWARENESS - Promote Awareness that suicide is a preventable public health problem.
    - INTERVENTION - Develop and implement suicide prevention programs
    - METHODOLOGY - Promote and support research on suicide and suicide prevention
  - For more information contact: Dr. Blaine Shaffer - Division of Behavioral Health Services
- Local Outreach to Suicide Survivors (LOSS) is a suicide postvention effort.
- Dave Tuttle, Suicide Prevention Coordinator, VA Hospital in Omaha - U.S. Department of Veterans' Affairs / Nebraska-Western Iowa Health System
- website for teachers "gatekeeper training" that have to take this training to become certified. This is a public domain web site for teachers (self training). www.sptsnj.org/index.html

A GOAL STATEMENT

A goal statement that if accomplished would place NE as a top five state in suicide prevention would be … Lowest suicide rate in the Nation in all age groups.

MEASUREMENTS

Suicide Deaths and Rates for Nebraska, Surrounding States and the US
2001 – 2005, by Age Groups (details attached)

State	Deaths	Crude Rate
Nebraska	917	12.27
Kansas	1,717	12.66
Iowa	1,644	12.85
Missouri	3,539	14.3
South Dakota	534	16.07
Colorado	3,774	19.24
U.S	158,765	12.66

This reports Nebraska had a total of 917 individual deaths by suicide over the five year period. That means an average of 183.4 deaths by suicide annually in NE.
NE, compared to surrounding states using the Crude rate, was lowest at 12.27.
Source: Web-based Injury Statistics Query and Reporting System reported by calendar year from the CDC web site: http://www.cdc.gov/ncipc/wisqars/

State of Nebraska	894	10.6

Source: DHHS Death Certificate Data 1999-2003

- Age adjusted rate per 100,000 population, based on the 2000 U.S. standard population
- Attached are charts from DHHS Division of Public Health EPI Staff. The 894 is for a five year time period, with annual average of 178.8.
- Data from the DHHS Child Death Review Team shows that NE teen suicide rate is higher than the national average. (see attached).

NE LEADERSHIP

- NE Suicide Prevention Coalition - Dave Miers, Don Belau, Denise Bulling, Peg Prusa-Ogea, and Blaine Shaffer

Nebraska Department of Health and Human Services

- Division of Public Health (Injury Prevention Program and Minority Health / NE Child Death Review Team, School and Child Health),
- Division of Children & Family Service (Youth Rehabilitation and Treatment Center / Geneva)
- Division of Behavioral Health

BUDGET ESTIMATES

The gap in this area involves formal statewide leadership by paid staff. To do this, $85,000 would be needed to contract for a Statewide Suicide Prevention Coordinator. The contract could be with an organization such as the University of Nebraska Public Policy Center.

EXAMPLES OF TRAINING

- Using EBP for Suicide Prevention.
  For Youth … yellow ribbon, Columbia Teen Screen, SOS
  Most will want Yellow Ribbon & SOS
  Need to work with State Dept of Education
- Local Outreach to Suicide Survivors (LOSS) program – is a pilot program in Lancaster County.
- Gatekeeper Training for teachers … course credit … linked to a web site …

Attachment 4

Nebraska Association of Area Agencies on Aging
115 North Vine, North Platte, NE 69101
(308) 535-8195 □ Fax: (308) 535-8190

July 23, 2008

Aging Office of Western NE
Bluffs Business Center
1517 Broadway Suite 122
Scottsbluff, NE 69361
Phone: (308) 635-0851
Fax: (308) 635-2321

Blue Rivers AAA
1901 Court Street
Beatrice, NE 68310
Phone: (402) 223-1352
Fax: (402) 228-3546

Eastern NE Office on Aging
4223 Center Street
Omaha, NE 68105-2498
Phone: (402) 444-6444
Fax: (402) 444-6503

Lincoln AAA
1005 "O" Street
Lincoln, NE 68508-3628
Phone: (402) 441-6157
Fax: (402) 441-6524

Midland AAA
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West Central NE AAA
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North Platte, NE 69101
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Nebraska Department of Health and Human Services
Scot Adams, Director of Behavioral Health Services
P.O. Box 95026
Lincoln, NE 68509-5026

Dear Scot,

The Nebraska Area Agencies on Aging welcomes this opportunity to provide the needs and critical issues of Nebraska's older adults and behavioral health.

The Area Agencies on Aging provide case management which identifies service needs of older adults. The process includes intake and screening, assessment, care planning, care plan implementation and ongoing monitoring. This is provided through the care management program and the Aged and Disabled Medicaid Waiver program. Referrals are received from many sources inclusive of families, physicians, hospitals, nursing home and human service agencies. Intake/screening assures that the services are provided to those that need them the most. Area Agency staff who provide this are registered nurses or social workers.

One area that is difficult to utilize for the older adults is behavioral health services. The service needs include:

> Depression, emergency crisis care, suicide threat, alcohol/drug misuse, hoarding behavior, grief/loss, homeless population, local doctors not up to date or educated on psychotropic medications, not enough psychiatrists/psychologists to provide service.

The older population feels the strong stigma of being labeled "mentally ill". This often can affect whether services will be accepted. In-home counseling would be one way to provide the service needed.

The Area Agencies on Aging can provide case studies that demonstrate the need for services:

- After two hours of calling all mental health resources, elderly client was sent to local ER and received care from general physician.
- Client suffering from depression made threats of suicide. On two occasions local county sheriff, APS and home health nurse called to home, no support was left for client and spouse. Events escalated, Sheriff EPC'd to local hospital. Client stayed two days without mental health assistance. Client moved to live with family where he was admitted to VA after family insisted he could not be home.

- Client residing in Assisted Living Facility was a continual problem for the facility, disrupting the life of other residents with aggressive behaviors. The client was irrational and noncompliant and was evicted. A facility was found out of state which provides services for older adults with mental health concerns.

Clearly, collaboration is needed with the Area Agencies on Aging, Behavioral Health, the State Unit on Aging, Assisted Living Facilities, Nursing Facilities, and other community organization.

We thank you for this opportunity and look forward to hearing from you.

Sincerely,

Linda S. Foreman

Linda Foreman,
Chairman, Nebraska Association of Area Agencies on Aging

Harvest Project
Service Impact Scale Definitions

Purpose:

1. Acuity rating for caseload control.
2. Longitudinal examination of the effectiveness of interventions.
3. Project evaluation.

Approach: Measure effect of efforts to reduce deficits or normalize.

Scale & Ratings:

Normal:	No evidence of a deficit in defined area.
Slight:	Perceptible evidence but not a factor requiring a response.
Moderate:	Is clearly evident with a debilitating effect which must be addressed
Severe:	Outweighs most concerns, among the central issues in the intervention.
Extreme:	Complete or nearly complete functional impairment. Immediate action required.

I. Aging, Mental Health, and Substance Abuse: Summary index or measure of the relative extent to which each issue is present. Denotes relative emphasis of intervention. Workload indicator.

2. Personal Index

Awareness of issues: Abilities in thinking, insight, collection, organization and use of information.

Demonstrates an awareness of problems and is able to articulate these clearly.
Expresses vague awareness, but unable to articulate the issues.
Impaired recognition of issues in several areas.
Demonstrates very limited recognition of depth and extent of issues.
Serious and extreme inability to see the issues at hand, often coupled with use of denial and avoidance.

2. **Personal Index (continued)**

Self Direction: Ability to assess circumstances, apply judgement and values, problem solve and make executable decisions.

Shows ability to independently plan and carry out activities related to oneself.
Is able to carry out daily activities and tasks with minimal prompting.
Needing frequent reassurance and direction.
Serious impairment in ability structure time and direct self. Needs external cues the majority of the time.
Total inability to direct the day-to-day activities of one's life.

Social Ability/Self Representation: Ability to carry out or transact own best interests and personal decisions. Ability to communicate needs and lodge requests.

Has adequate social skills to interact in most social settings with limited discomfort.
Able to articulate needs clearly.
Demonstrates some impairment in social interactions and in self-presentation.
Displays marked impairment in social situations and in self assertion regarding needs. Tendencies to remain quiet, self-deprecating or unsure of self.
Requires frequent intervention to assist in easing social interactions and in articulating needs clearly.
Extreme isolation, social withdrawal and overall inability to present self to others or to assert needs.

Means and Motivation to Change: Possesses physical assets, telephones, transportation, clothing to transact change. Willingness to utilize personal & physical assets to transact change.

Actively and consistently is able to and willing to work on issues and is accepting of assistance from others.
Shows minor difficulty with or variation in level of motivation. Some tendencies to shy away from external supports.
Noticeable variations in motivation and only sporadic use of support systems.
Demonstrates major problems with motivation. Impaired ability to reach out to supports.
Client unable or unwilling to accept outside assistance. Sees no reason to change life's situation and level of impairment prevents motivation for change.

2. **Personal Index (continued)**

Physical Functioning: Ability to perform instrumental activities necessary to resolve concerns and conduct of activities of daily living.

No deficits in physical functioning at this time.
Physical deficits are apparent, however individual is usually able to function within the parameters of any limitations.
Physical issues are ongoing and effect the person's ability to carry on with activities of daily living.
Severe physical deficits which need intervention and assistance in order to maintain independence.
Physical deficits are severe enough to necessitate 24-hour care. Unable to care for self.

3. **Social Index:**

Threat to Self or Others: Danger on injury to self or others through suicidal or homicidal statements, gestures or attempts. Exhibiting harmful or dangerous behaviors, or neglect of basic needs.

Impact on Others: Negative effect on emotional, financial or physical well-being of others via inappropriate behaviors or life circumstance.

Abuse/Neglect by Others: Mistreatment of client by another individual through physical or sexual abuse, neglect or fraud.

Interference: Involvement by support system members or community members which hinders client's ability to maintain independence or to make positive life changes.

4. **Situational Index**

Situational Stability: Degree to which the situation contains volatile elements which are apt to worsen quickly.

Issue Complexity\Severity: Overall number and relative seriousness of central issues which require attention in an intervention.

Environment Hazard: Extent to which the physical environment poses a threat. Includes substandard housing, filth, fire, pestilence, cluttering, communicable disease, animal control, hazardous material, and other issues.

Situational Pain: Degree of emotional discomfort created by the entire situation for the client and/or the community, friends, neighbors, and relatives.

Harvest Project
Service Impact Scale

Date:_____/___/_____

Next Rating Date:___/___/___

Staff Initials:_____ Client SSN:_____ Client DOB:_____

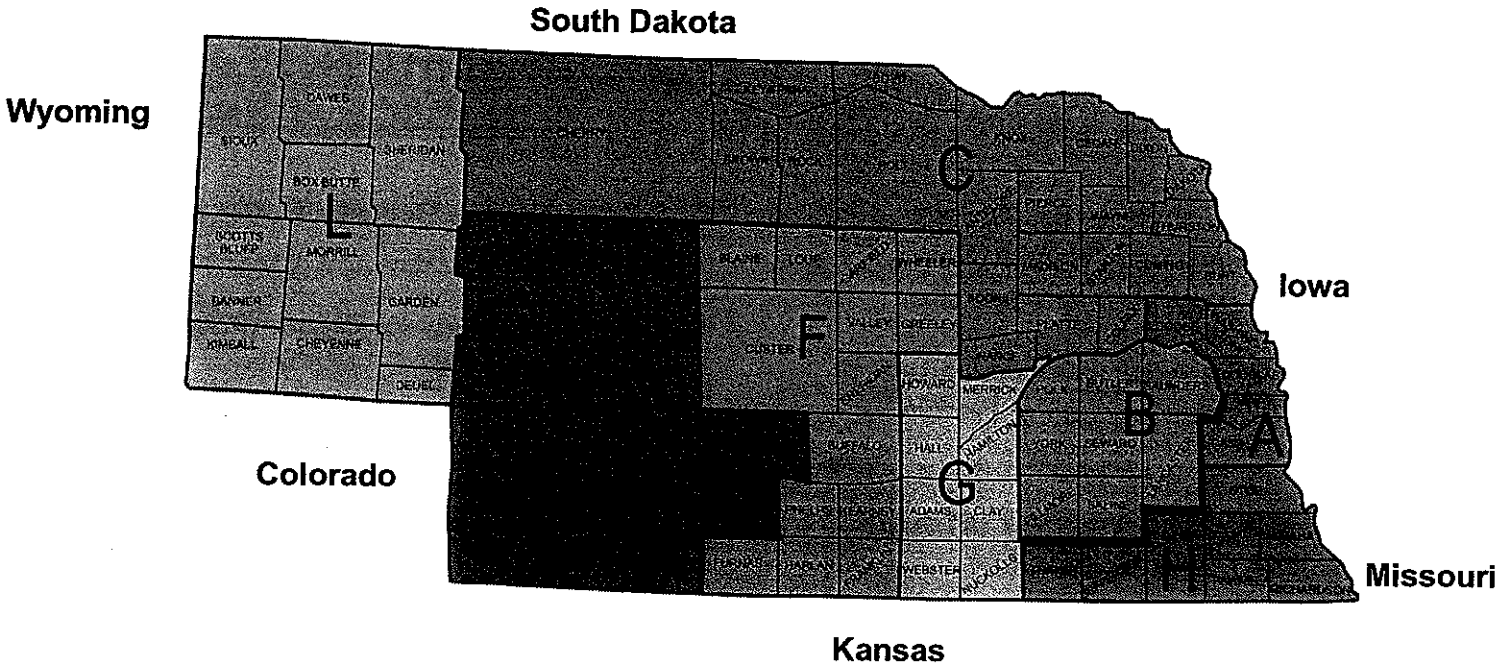
Client Name: _____ _____ _____ Client CR# _____

First *MI* *Last*

Summary Rating	Normal 0	Slight 1	Moderate 2	Severe 3	Extreme 4
Aging					
Mental Health					
Substance Abuse					
Personal Index:					
Awareness of Issues					
Self-Direction					
Social Abilities\ Self-Representation					
Means & Assets					
Motivation to Change/Use of Supports					
Physical Functioning					
					Personal Index SubTotal
Social Index:					
Threat to Self					
Effect on Others					
Abuse\Neglect by Others\Fraud					
Interference					
					Social Index SubTotal
Situational Index:					
Situational Stability					
Issue Complexity\Severity					
Environmental Hazard					
Situational Pain\Danger					
					Situational Index SubTotal
					Total Score

Client Status: ☐ Active

☐ Closed Date: ___/___/_____ ☐ Inactive___/___/_____



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Website: lincoln.ne.gov Keyword: aging

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Administrative Fax: 308-535-8197
CHOICES Program Fax: 308-535-8190
Toll Free: 800-662-2961

L. AGING OFFICE OF WESTERN NEBRASKA
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AAA BOARD CHAIR

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Mary Ann Borgeson, Board Chair

Lincoln Area Agency on Aging
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Northeast NE Area Agency on Aging
Richard Uhlir, Board Chair

South Central NE Area Agency on Aging

Midland Area Agency on Aging
Pam Lancaster, Board Chair

Blue Rivers Area Agency on Aging
Ivan Zimmerman, Board Chair

West Central NE Area Agency on Aging
Glen Monter, Board Chair

Aging Office of Western NE
Clint Bailey, Board Chair

COUNTIES WITHIN PLANNING & SERVICE AREAS

A - Cass, Dodge, Douglas, Sarpy, and Washington

B - Butler, Fillmore, Lancaster, Polk, Saline, Saunders, Seward, and York

C - Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, and Wayne

F - Blaine, Buffalo, Custer, Franklin, Furnas, Garfield, Greeley, Harlan, Kearney, Loup, Phelps, Sherman, Valley, and Wheeler

G - Adams, Clay, Hall, Hamilton, Howard, Merrick, Nuckolls, and Webster

H - Gage, Jefferson, Johnson, Nemaha, Otoe, Pawnee, Richardson, and Thayer

J - Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, and Thomas

L - Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, and Sioux

NEBRASKA DEPARTMENT OF HEALTH & HUMAN SERVICES
Division of Medicaid & Long Term Care
STATE UNIT ON AGING
Sarah Briggs, Administrator
P.O. Box 95044
Lincoln, NE 68509-5044
402-471-2307
1-800-942-7830 in Nebraska

Attachment 5 & 6

Continuous Quality Improvement (CQI)

CQI

- An ongoing process of using data to plan, identify, study and implement ongoing improvements, celebrate progress, change and success.
  - No matter how good we are, there is always room for improvement.
  - Focus on systems, processes.
  - Small, incremental changes

CQI

- The CQI program should reflect not just measurement but actual improvement of services and service provision in accordance with the wishes and needs of the community/individuals being served.

CQI

- CQI is ultimately about learning! It is about delving into details. What do the details say?
  - It says right here we're rock stars!
  - I have no idea what this means!
  - It should not be about judgment/blame but how can we improve?

CQI

- **Challenging ourselves to be <u>ACCOUNTABLE</u> to delivering the highest quality services to the community and state's consumers and families in a cost effective manner.**

The CQI Program

- Links data, knowledge, structures (resources, licensure, capacities) processes and outcomes in order to improve through out a system.

Assumptions

- If you've seen one region, you've seen one region!!
- Working together creates a system of coordinated services to better meet the needs of individuals and families.
- We want to improve outcomes.
- Providers participate and monitor services and participate in data reporting.

Key Aspects

- Services are designed to meet consumer/family need and are **accessible** when needed;
- **Consumers and families participate** in all processes of the CQI program and their views and perspectives are valued;
- The services provided incorporate **evidenced based practices, best and promising practices**;
- Services are of **high quality** and provided in a **cost-effective** manner.

CQI Core Principles

- **Customer focus**
  - Understanding and respecting needs and requirements of all customers and striving to exceed expectations.

- **Builds on strengths** of the system and individuals
  - Required for growth and change

CQI Core Principles

- **Commitment to best practice**
  - Customers deserve services that represent the best practices in the field of behavioral health
    - Benchmark and compare.

CQI Core Principles

- **Representative participation and involvement**
  - Providing participants the resources, education and opportunity to make improvements required and influence decision making.
  - Diverse representation of stakeholders

- **Integrated into every thing, every day**
  - Create the culture and environment that support a continuous improvement process.
    - **Communication is key.**
    - **Do we support and include the QI costs in rates, etc.**

CQI Core Principles

- **Results-based decision making**
  - Developing, operating, and improving services with a focus on **outcomes** and use of **reliable, meaningful data** and thoughtful **analysis.**
    - **Commitment to seek IT structure, staff, skills and other resources needed.**

Performance Contracting

- Purpose:
  - Improve services and reward improvements.
  - Improve outcomes -reinforce progressive improvements that promote recovery and quality of life.
  - Public reporting and recognition of performance.

Performance Measures

- Should be meaningful to stakeholders
- Should be developed with all stakeholders
- Should be finalized annually through a collaborative process
- Focus on a few, simple, clear measures each year

Performance Measure Selection

- Should be based on what stakeholders want system to achieve
- Should consider data available
- Should consider provider reporting burdens/time

NOMS = Access/Capacity	Consumer/Family Questions	System Level Questions	Outcomes	Measures
	How soon can I get in? Can I get in no matter what "door" I enter? Are the services going to meet my age, culture, language, gender needs?	How accessible are services? How much time do consumers wait between levels of service? Do we have enough capacity and/or proper mix of services? What is service utilization verses service capacity regionally and across the state?	NOMS = There is an increase in access to services(service capacity.) There is an array of services that can be accessed statewide in a timely manner to support individuals and families in their recovery.	NOMS MH = # of persons served by age, gender, race and ethnicity NOMS SA = Unduplicated count of persons served; penetration rate #served compared to those in need NOMS Prev = # of persons served by age, gender, race and ethnicity Director = # of days on the wait list for Regional Center Services and Community Based Services.

SQIT

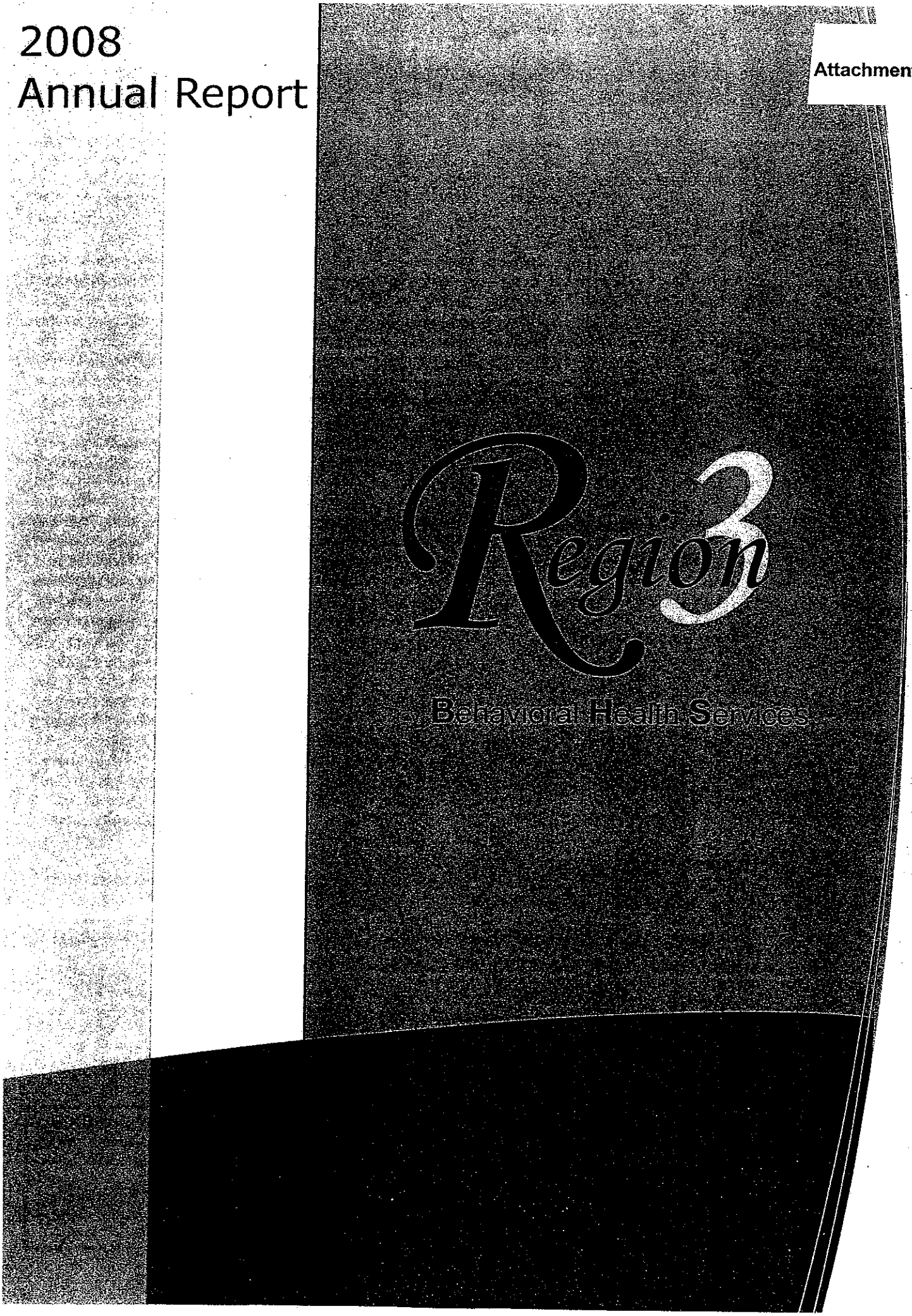
NOMS = Perception of Care and Social Connectedness	Consumer/Family Questions	System Level Questions	Outcomes	Measures
	Is the system respectful of my recovery, goals and interests? Do the services help my life? Does my point of view count?	How satisfied are individuals and families with services? How well and which services and providers promote recovery? How trauma-informed is our system? How can we systematically promote recovery?	NOMS MH = Client Perception of Care2 NOMS MH/SA = Increased social supports/social connectedness1. The service delivery system is perceived to be recovery oriented. Individuals and families seeking services will be full partners in their service planning and delivery.	PERCEPTION OF CARE NOMS MH = Increase in the of individuals reporting positively about outcomes NOMS SA = Under development NOMS Prev = N/A SOCIAL CONNECTEDNESS NOMS MH = Increase in the # of individuals reporting positively about social connecteness. NOMS SA = Under development NOMS Prev = N/A

	Consumer/Family Questions	System Level Questions	Outcomes	Measures
NOMS = Reduced Morbity	What can be done to improve my mental and physical health?	Are the services we purchase keeping individuals out of the hospital and in the community?	NOMS MH = Decreased MI symptomatology NOMS SA = Abstinence from Drug/Alcohol Use Individuals will live in communities of their choice, direct their lives to attain the maximum level of independence and self-sufficiency; experience improved mental and physical health.	NOMS MH = Under development NOMS SA = Reduction in/no change in frequency of use at date of last service compared to date of first service NOMS Prev = 30 day substance use (non-use/reduction in use); Perceived risk/harm of use; age of first use; perception of disapproval/attitude
NOMS = Crime and Criminal Justice	Who will help me if I go to jail?	What can be done to promote integration of service for an individual in the criminal justice system?	NOMS MH = Under development NOMS SA/Prev = Decreased Criminal Justice Involvement	NOMS MH = Under development NOMS SA = Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service NOMS Prev = Alcohol related care crashes and injuries; alcohol and drug-related crimes
NOMS = Retention	Do I have all the services and supports I need to keep me healthy?	Are the services purchased keeping individuals out of the hospital and living in the community and increasing retention in SA services?	NOMS MH = Reduced Utilization of Psychiatric Inpatient Beds - MH NOMS SA = Increased retention in SA Treatment Increased Community Tenure	NOMS MH = Decreased rate of readmission to State Psychiatric hospitals (contracted hospitals) within 30 days and 180 days NOMS SA = Length of stay from date of first service to date of last service and unduplicated count of persons served NOMS Prev = Total number of evidenced based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message. Director = rate of involuntary admissions (EPC's and commitments)per 1,000 or per admissions
NOMS = Use of EBP	Is the service really based on evidence and will it work? Is the staff trained?	Does the system encourage and support the use of EBP, best and promising practices?	NOMS MH/SA = Use of evidenced based practices 2	NOMS MH/SA = Under development NOMS Prev = Total number of evidence based programs and strategies.
NOMS = Stability in Housing	Where do I live when I leave service and can I get services where I live?	What housing options can be developed to meet the housing needs?	NOMS = Increase in Stability in Housing	NOMS MH = Profile of adult clients change in living situation (including homelessness). NOMS SA = Increase in/no change in number of clients in stable housing situation from date of first service to date of last service. NOMS Prev = Not applicable
NOMS = Employment/Education	Can I work and still get my medications and other benefits? What school or training options are available for me?	What can be done to promote employment and education opportunities for individuals served?	NOMS = Increased /Retained Employment or Return to/Stay in School	NOMS MH = Profile of adult clients by employment status and of children by increased school attendance. NOMS SA = Increase in/no change in number of employed or in school at date of last service compared to first service. NOMS Prev = Not applicable

NOMS = Cost Effectiveness	Consumer/Family Questions	System Level Questions	Outcomes	Measures
	How much do I pay for services?	Are the services cost effective?	Services purchased are of high quality and cost effective through out the service delivery system. NOMS = Cost Effectiveness (Avg Cost)2	NOMS - MH/SA Under Development NOMS - Prevention : Services provided within cost bands.

2008 Annual Report

Attachment 7



Regional Governing Board Members

Adams County
Jack Hynes
Blaine County
Kay Anderson
Buffalo County
Sherry Morrow
Clay County
Ivan Fintel
Custer County
*Larry Hickenbottom
Franklin County
*David Walton
Furnas County
Clinton Olmsted
Garfield County
Marty Robbins
Greeley County
Doug Wrede
Hall County
*Jim Eriksen
Hamilton County
Larry Fox
Harlan County
Ruby Hardin
Howard County
Bill Sack
Kearney County
Jean Rush
Loup County
William Weber
Merrick County
John Jefferson
Nuckolls County
Michael Combs
Phelps County
Rodale Emken
Sherman County
Richard Panowicz
Valley County
Helen Cullers
Webster County
Mary Delka
Wheeler County
Jim Hoerle

*denotes Executive Committee

A message from the Chairperson of the Regional Governing Board and the Regional Administrator...

Fiscal year 2008 brought many rewards and challenges to Region 3 Behavioral Health Services (Region 3). The challenges we experienced provided opportunities for our system to explore ways to improve and remain dynamic. The rewards we've experienced are seeing the many children and adults who have been served by our system experience community life in a positive manner.

Recovery is not a step-by-step process, but one based on continual growth, occasional setbacks, and learning from experience (Consensus Statement on Behavioral Health Recovery). We acknowledge that recovery is the unifying and desired outcome of the Region 3 Behavioral Health System. The expansion of recovery oriented services throughout the past few years has helped transform our system. Through transformation efforts consumers now have more opportunities than ever before to direct their own care and be supported by peers in formalized peer support services. Peer support services are now provided by five agencies in the Region 3 Behavioral Health Services Network across several levels of care.

As we look back over the past year we would like to thank the many system partners who have joined us in our efforts to transform our behavioral health system. We wish to thank the Regional Governing Board, the Behavioral Health Advisory Committee, and the Regional Consumer Advisory Council for providing leadership in our transformation efforts and supporting the many activities designed to improve the behavioral health system. We are greatly appreciative of Region 3 Behavioral Health Network providers who have been willing to develop and expand services in order to address the needs of the many individuals and families who need treatment and support. And finally, we would like to express our gratitude to our many system partners who have been willing to share their expertise, resources and time in being solution focused in helping the system to be responsive to the many needs of those we all serve.

Each year brings many opportunities for Region 3. As we move forward we will continue our work with system partners in the transformation of both the child and adult service delivery systems to ensure that individuals across the life span can achieve recovery as recovery provides the essential and motivating message of a brighter future.

Beth Baxter
Regional Administrator

Dave Walton
Chairperson

Behavioral Health Advisory Committee

Judy Vohland, Chairperson	Alethier Evans	John Jefferson	Cindy Scott
Wayne Adamson	Dwain Fowler	Chris Klein	Mary Wells
Patsy Burnett	Susan Henrie	Brenda Miner	
Cheryl Crouse	Bill Holloway	Anne Rohan	
Mary Delka	Randy Huss	Merv Schliefert	

Region 3's programs accredited by CARF:
Prevention Center
Professional Partner Program
Emergency Community Support

Mission
Our mission, at Region 3 Behavioral Health Services, is to provide leadership, be attentive to stakeholders, organize, collaborate, and coordinate the provision of an integrated, effective, and efficient array of community-based behavioral health services for people of Central and South Central Nebraska in a strength-based and culturally competent manner.

Behavioral Health Reform in Region 3

Behavioral Health Reform continues to be an important avenue to improve the management of the Region 3 Behavioral Health System and ensure that individuals across the life span can fully participate in their communities. Beginning in 2003 Region 3 formalized system wide planning with stakeholders to identify strengths, needs, barriers and strategies to address system needs. Behavioral Health Reform efforts continued through the passing of LB1083, the Nebraska Behavioral Health Services Act, in April 2004 and throughout subsequent years.

Region 3 has achieved the initial goals outlined in behavioral health reform.

- There has been an 86% decrease in the utilization of Regional Center services. Acute services are being provided in the community by Richard Young Hospital (RYH) in Kearney and Mary Lanning Memorial Hospital in Hastings. Additionally, RYH provides subacute services to further support an individual's recovery.

- There has been a 38% increase in the utilization of community-based services with the development and expansion of services provided through the Region 3 Behavioral Health Services Provider Network.

- Through the development and expansion of a comprehensive array of emergency psychiatric services, there has been significant improvement in the system's response to individuals experiencing a psychiatric crisis (data from the period of July 1, 2004 through June 30, 2008).
  - 21.6% decrease in Emergency Protective Custody (EPC) situations
  - 30.4% decrease in Inpatient Commitments
  - 25.5% decrease in the number of Mental Health Board Hearings
  - 20.0 % decrease in repeat EPCs

- There has been a dramatic increase in Peer Support services throughout the service array designed to assist individuals who experience a behavioral health disorder by promoting personal growth, self-esteem, and dignity by developing leadership and advocacy skills, and sharing information.

Region 3 has experienced an infusion of new funding to develop new and expanded services and system coordination. As consumers were transitioned to community-based care and the census of the three regional centers in Nebraska was reduced, Behavioral Health Reform provided for funding to be transferred to the community to support consumers in community-based behavioral health services.

- In FY04 Region 3 expended a total of $7,750,391 for behavioral health network management, system coordination and the provision for behavioral health services (state, federal and county funds). In FY08 Region 3 expended a total of $12,300,678 for these activities. This represents a 59% increase in funding for community-based services.

- LB959 approved by the Nebraska Legislature during the 2008 Legislative sesssion provided one-time funding for community-based services across Nebraska. On May 30, 2008 Region 3 received $1,538,550 in additional one-time funding through LB959. Priorities for the one-time funds include:
  - Reducing the Census at Regional Centers/Services for Special Populations
  - Providing Crisis Care
  - Recovery and Consumer Involvement that Facilitates Recovery and Builds Resilience
  - Activities that Prevent Utilization of Higher Levels of Care
  - Workforce and Infrastructure Development

Region 3 is committed to making the system effective and efficient and will continue its work with system partners in the transformation of both the child and adult service delivery systems to ensure that individuals across the life span can achieve recovery. One thing Region 3 has emphasized over the years is that, systemically, challenges can be addressed and Region 3 system partners have a long-standing reputation of coming together to develop creative solutions to improving our behavioral health system.

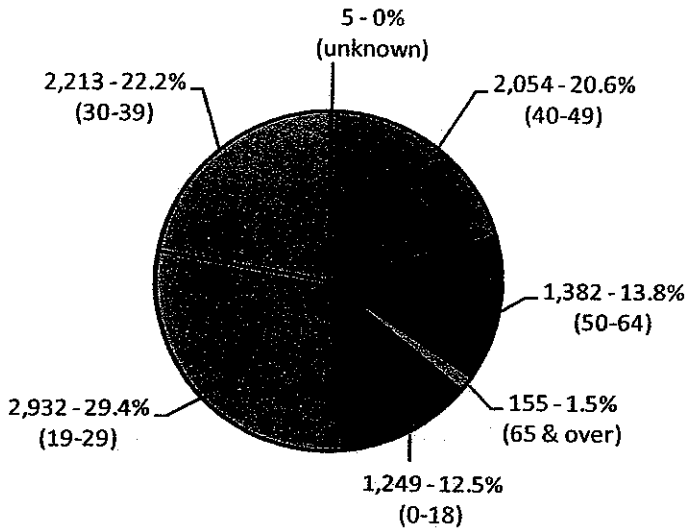
Network Management - Coordinating Resources

Region 3 Network Management assists in developing, implementing and evaluating regional behavioral health service needs, goals, and programs to ensure that the behavioral health system in Central and South Central Nebraksa operates in an effective and coordinated manner.

Network Management determines minimum standards for behavioral health providers, manages provider enrollment, determines the capacity necessary to provide a balanced behavioral health system and provides technical assistance to providers as needed.

During FY08 a total of 9,990 individuals were served by Region 3 Behavioral Health Services Network providers. Five percent of those served were from counties outside the Region 3 geographic area. 12.5% of those served were under the age of 19 and 87.5% were 19 and older. The largest age group served (29.4%) was between the ages of 19-29 followed by 22.2% of those served being between the ages of 30-39.

Ages of Persons Served
FY08
(n=9,990)

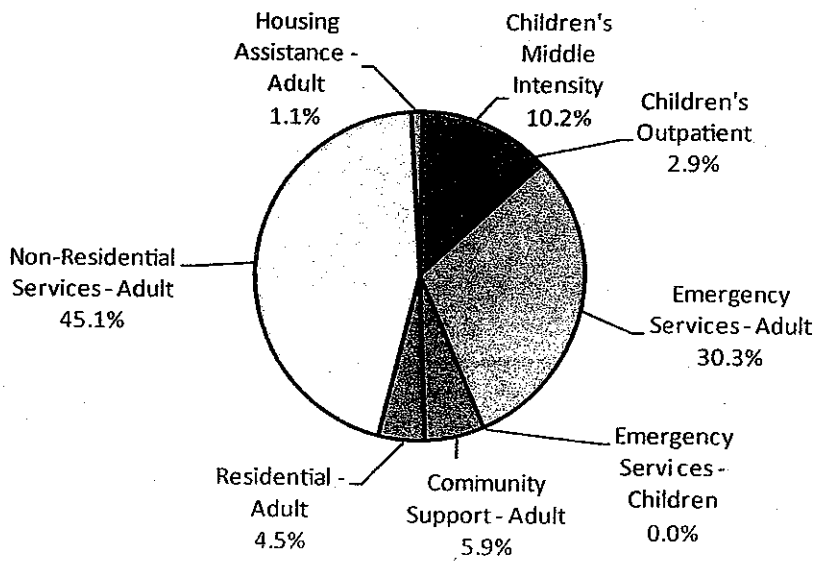


Quick Facts

- 87% of those served had an annual income of less than $20,000
- Almost 68% had no insurance
- 35% served had a primary disgnosis of substance abuse/dependence disorder
- 44% of the individuals served either experienced a severe and persistent mental illness or a serious emotional disorder

The graph to the right provides information regarding the percentage of people served by level of care. Many individuals may be involved in more than one level of care depending upon their behavioral health needs.

Persons Served by Level of Care
FY08



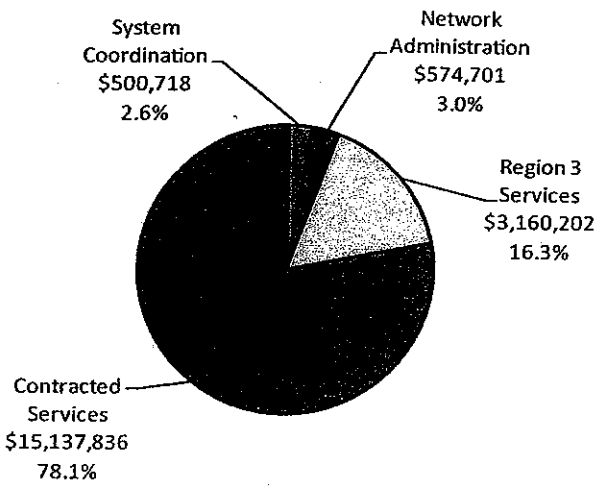
Fiscal Management

Region 3 is accountable for all sources and expenditures of public behavioral health funds (federal, state, and county) it administers. Region 3 utilizes contract monitoring, the tracking of outcome and performance standards, and fiscal and programmatic reviews of network providers to ensure the effective and efficient utilization of public resources. On an annual basis Region 3, in collaboration with the Regional Behavioral Health Advisory Committee, the Region 3 Behavioral Health Services Network, and other stakeholders, develops and submits an annual budget plan to the Department of Health and Human Services, Division of Behavioral Health (Division) outlining the types of services to be funded and the funding to be allocated for such services. Region 3 reports to the Division on an annual basis the utilization of funds across the continuum of care.

Region 3 also contracts with the Division of Children and Family Services for the provision of case management services through the Integrated Care Coordination Unit (ICCU). The ICCU serves children and adolescents who have multiple and complex needs and are in the custody of the Department of Health and Human Services. This agreement also funds family empowerment, support and youth leadership activities provided by Families CARE.

Region 3 expended a total of $19,373,457 in fiscal year 2008. 78.1% of the funds expended were for the purchase of services for individuals and families served by the Region 3 Behavioral Health Services Network. 16.3% of the funds expended were for therapeutic case management services for children and adults provided directly by Region 3. System coordination accounted for 2.6% of the expenditures and 3.0% was expended for network administration activities.

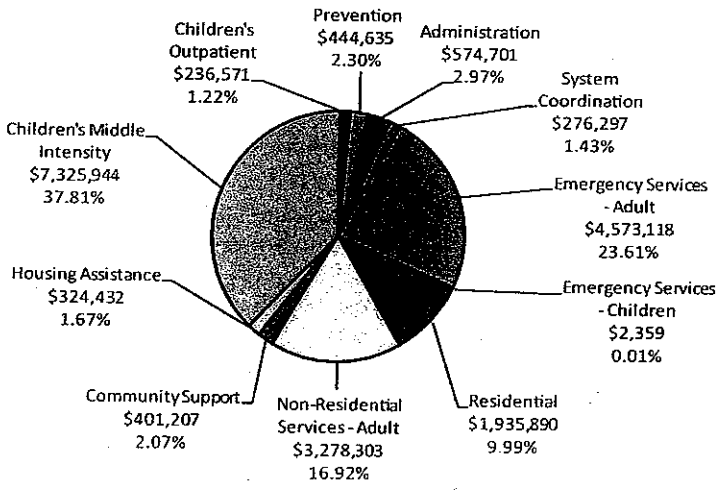
Fiscal Year 2008 Total Expenditures



Balance Sheet June 30, 2008 Audited		
Total Assets		$5,866,404
Total Liabilities		$4,867,046
Fund Balance:		
Reserved	$423,159	
Unreserved	$999,358	
Net Assets of Governmental Activities		$1,422,517

The chart to the right shows the FY08 expenditures by level of care. 54.3% was expended for services for adults and 39% was expended for children's behavioral health services. Prevention services are designed to serve people across the life span and accounted for 2.3% of the overall expenditures during FY08.

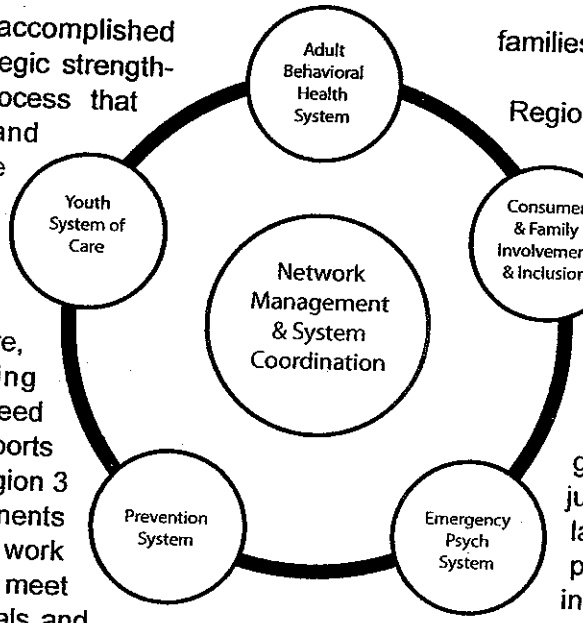
Expenditures by Level of Care FY08



System Coordination - Building on Individual, Community and System Strengths

System Coordination is accomplished through a well planned strategic strength-based, recovery-focused process that empowers individuals and communities to achieve positive results.

A behavioral health disorder impacts every aspect of an individuals' life. Therefore, individuals experiencing behavioral health disorders need many kinds of services and supports from a variety of sources. Region 3 works to ensure that components of the service delivery system work in a coordinated manner to meet the unique needs of individuals and families who seek assistance.



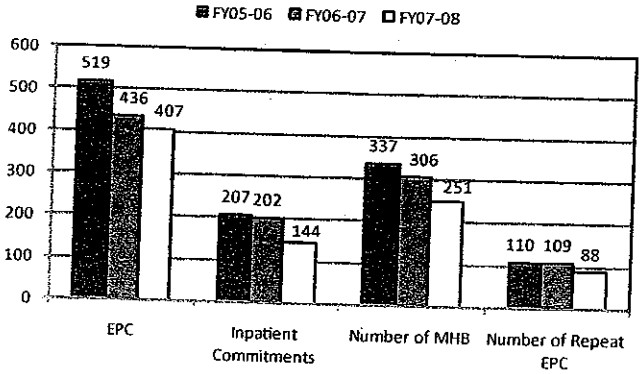
Region 3 System Coordination assists in the development, implementation and evaluation of service needs, barriers to effective service delivery, and the identification of strategies to address individual, programmatic and system needs. Region 3 works closely with service providers, community representatives, consumer groups, and representatives of judicial, education, social services, law enforcement, and healthcare providers to create a climate for inter-agency collaboration and systems integration.

Adult Behavioral Health System Coordination manages provider enrollment in the Region 3 Behavioral Health Services Network and assists with program certification. Adult System Coordination facilitates the agency unit audit and programmatic review process to ensure that services are provided according to related standards. Service capacity and utilization is monitored on a continual basis to track service demand trends, waiting lists, and to ensure individuals have access to needed treatment and support.

Emergency System Coordination - Region 3 experienced a 7% decease in Emergency Protective Custody (EPC) situations from FY07 to FY08 with a total decrease of 22% in EPCs over the past two fiscal years combined. Additionally, there has been a 29% reduction in Mental Health Board inpatient commitments during the last fiscal year and an 18% reduction in Mental Health Board hearings from FY07 to FY08 with a total of 26% reduction in the past two fiscal years. Region 3 experienced a 19% decrease in repeat EPC admissions within a 12-month period in FY08 as compared to FY07. From the beginning of Behavioral Health Reform in July 2004 through June 30, 2008, Region 3 has experienced an 86% reduction in the number of consumers served in a regional center.

During FY08 Region 3 has experienced the impact of Mid-Plains Center for Behavioral Healthcare Services' Crisis Stabilization Unit (CSU) on the behavioral health system. The CSU allows consumers voluntary crisis stabilization in a supportive environment with 24/7 medical care available. This service has assisted in reducing EPCs by offering consumers a safe environment for stabilization.

Region 3 Emergency System EPC, Inpatient Commitments, Mental Health Board Hearings & Repeat EPCs by Fiscal Year



System Coordination - Building on Individual, Community and System Strengths

Consumer and Family System Coordination works toward full and meaningful consumer and family involvement and inclusion in all aspects of the Nebraska Behavioral Health System. These efforts are facilitated by the Regional Consumer Specialist (RCS) who works in close collaboration with consumers of behavioral health services as well as professional staff and state administrators within the Nebraska Behavioral Health System advocating for consumer views and to achieve meaningful integration of consumers as a priority in the system. The RCS serves as an advocate and liaison to consumers of behavioral health services which are designed to lead toward wellness and recovery from mental illness, substance abuse, or problem gambling.

The RCS serves as an ambassador of recovery and wellness and is a trained facilitator of Wellness Recovery Action Planning (WRAP); teaching a lifestyle of wellness and developing independence through personal responsibility. This year, consumers have used this training to reinforce their transition back into their community and it has given them new skills upon which to build resilience and hope.

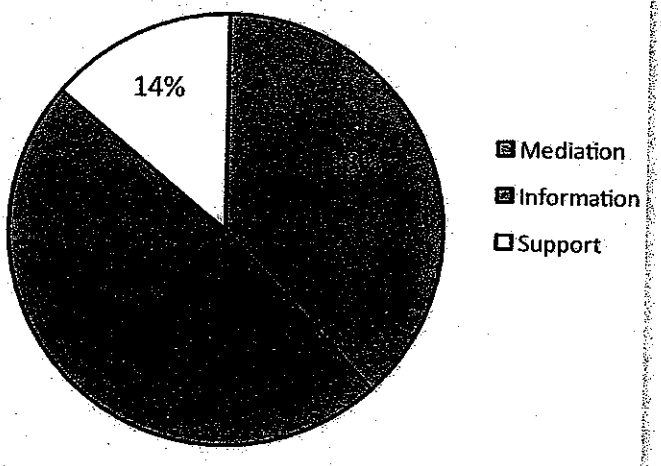
A Regional Consumer Advisory Council has been formed and meets on a quarterly basis to identify barriers and collectively seek solutions. This council has given consumers a unified voice and has nurtured advocacy and leadership within it's membership.

Peer Support utilizes the power of mutuality and supports recovery through role-modeling and relationships. Peer Support is currently considered a critical ingredient in a "recovery-oriented" system of care as defined by the President's New Freedom Commission Report. Region 3 recognizes its value to recovery and funds peer support to deliver services to consumers in a variety of settings across the Region.

The RCS continues to be a consistent participant in all system planning and implementation. The RCS, along with other peers, has attended regional strategic planning meetings that determine one-time funding distribution. Consumers are also involved in state-wide behavioral health initiatives and are regarded as meaningful stakeholders in strategic meetings.

The RCS is a primary advocate for consumers and their family members. Consumers contact the

Region 3 Consumer Contacts FY08



Consumer Specialist for assistance with mediation, support or information. During FY08 the RCS received 33 requests for assistance. Of the 33, 7 were family members and 26 were consumers. Examples of mediation would include participation in a meeting between a service provider and a consumer. Often the RCS can provide mediation and representation during negotiations which might otherwise be too intimidating to a consumer. The RCS receives regular requests for information. Consumers and family members request information on topics such as provider services and eligibility for service. Support is key in reaching recovery. On occasion, a consumer may want emotional support from within a hospital. The Consumer Specialist plays an important role in supporting peers and family members with their path to recovery by proving hope and encouragement to people during challenging times.

System Coordination - Building on Individual, Community and System Strengths

Regional Prevention System Coordination utilizes the Strategic Prevention Framework to guide prevention activities throughout the 22 county area to provide the training, technical support and monitoring necessary to ensure that identified communities are successful in their prevention efforts. Region 3 Prevention staff coordinate prevention activities within the region and relate federal block grant funding recommendations to local coalitions and organized community initiatives. Regional Prevention Coordination identifies and mobilizes new communities to implement local prevention strategies and provides technical assistance to communities on how to apply for Federal Block Grant funding from Region 3 to initiate their prevention strategies. Region 3 expended $444,635 for prevention activities throughout FY08.

Fiscal year 2008 was a transitional year for the Region 3 Prevention System. Historically, Federal Prevention Block Grant dollars had been allocated to agencies providing prevention services in communities. Beginning in FY08, Region 3 contracted with five community coalitions to provide prevention services: Grand Island Substance Abuse Prevention Coalition, South Central Substance Abuse Prevention Coalition, Sherman County Prevention Policy Board, Garfield-Loup-Wheeler Children's Council and Positive Pressure Coalition of Buffalo County. This locally-responsive method of funding prevention policies, practices and programs was designed to facilitate the implementation of the Strategic Prevention Framework planning process to collect local and regional baseline Federal National Outcome Measurement requirements.

The regional prevention system continued to collaborate with key system partners including public health districts, education, community coalitions, higher education, Extension, drug-free youth groups, and prevention providers to ensure an integrated, continuum of prevention services.

Fifteen community groups in the Region 3 service area were awarded $10,000 in prevention mini-grant funds. Mini-grants provided seed dollars for communities to initiate strategies to address locally identified prevention needs.

Community coalitions in the Region 3 area were engaged in community mobilization and/or community planning for substance abuse prevention. Our prevention staff provided technical assistance regarding funding streams, coalition development, sustainability, and resource utilization. These coalitions will be primed to apply for the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) that will be available to community coalitions in Fiscal Year 2009.

Youth System of Care Coordination improves the provision of services for children and adolescents who experience a behavioral health disorder and their families by applying core values and guiding principles to the design and delivery of services and supports.

Region 3 assists in developing, implementing and evaluating regional service needs, goals, programs, and delivery systems in behavioral health areas. Region 3 also works closely with service providers, community representatives, consumer groups, and representatives of judicial, education, social services, and service providers to create a climate for interagency collaboration and systems integration of behavioral healthcare services as gaps and needs are identified within the Region 3 service area.

Youth System of Care	
Core Values	Guiding Principles
Child centered and family focused	- Comprehensive service array - Individualized care
Community-based	- Services in the least restrictive, most normalized environment that meets the needs of the child - Case management is provided to navigate the system and link the child and family to appropriate services and supports
Culturally competent	- Early identification and intervention - Smooth transition to adult service system - The rights of children and their families are protected

Region 3 Network Provider Adult Service Array

During FY08 Region 3 expended a total of $10,723,483 for the purchase of services and supports across the service array for 8,741 adults with behavioral health disorders, consumer empowerment and system coordination activities. Region 3 contracts with the agencies listed below for a comprehensive array of behavioral health services.

Behavioral Health Specialists/Seekers of Serenity
- Short-Term Residential
- Social Detox

The Bridge
- Therapeutic Community (women and their children)

Goodwill Industries of Greater Nebraska
- Community Support
- Day Rehabilitation
- Day Support
- Emergency Community Support
- Peer Support
- Supported Employment

Catholic Charities of Greater Nebraska
- Dual Diagnosis Residential Treatment

Friendship House/Milne Detox
- Halfway House
- Social Detox

Region 3 Behavioral Health Services
- Emergency Community Support

South Central Behavioral Services
- Assertive Community Treatment (ACT)
- Community Support
- Peer Support
- Day Rehabilitation
- Day Support
- Halfway House
- Crisis Response Team (collaboration with Mid-Plains Center)
- Medication Management (collaboration with Mary Lanning Memorial Hospital in Kearney)
- Mental Health Outpatient Therapy/Assessment
- Psychiatric Residential Rehabilitation
- Specialized Women's Treatment Program
- Substance Abuse Intensive Outpatient
- Substance Abuse Outpatient Therapy/Assessment

Mary Lanning Memorial Hospital
- Acute Inpatient
- Emergency Community Support
- Emergency Protective Custody
- Medication Management
- Behavioral Health Consultation and Support for Nursing Homes

Mid-Plains Center for Behavioral Healthcare Services
- Dual Diagnosis Outpatient Therapy/Assessment
- Medication Management
- Mental Health Outpatient Therapy/Assessment
- Crisis Stabilization Unit
  - Triage Center
  - Crisis Response Team
  - Urgent Medication Management
  - Urgent Outpatient
  - Crisis Stabilization
  - Medically Supported Detox
  - Peer Support

Richard Young Hospital
- Acute Inpatient
- Subacute Inpatient
- Emergency Protective Custody
- Medication Management
- Peer Support

St. Francis Alcohol & Drug Treatment Center
- Short-Term Residential
- Specialized Women's Treatment Program
- Substance Abuse Intensive Outpatient
- Substance Abuse Outpatient Therapy/Assessment

Region 3 Network Provider Children's Service Array

During FY08 Region 3 expended a total of $7,630,638 for the support of family empowerment, youth leadership activities, the purchase of services for children and their families, therapeutic case management, evaluation and system coordination activities. A total of 1,249 children and adolescents with behavioral health challenges and their families were served. Region 3 contracts with the agencies listed below to provide a variety of services and supports to children and adolescents and their families.

Center for Psychological Services
- 24-Hour Crisis Services
- Mobile Crisis Services
- School-Based Outpatient

Families CARE
- Family CARE Partners
- Family Evaluation
  - Wraparound Fidelity
  - Consumer Satisfaction
- Youth for Youth Support Group
- Parents for Change

Mid-Plains Center for Behavioral Healthcare Services
- Children's Day Treatment
- Medication Management
- Mental Health Outpatient Therapy/Assessment
- Multisystemic Therapy (MST)

Richard H. Young Hospital
- Crisis Inpatient Services
- Medication Management

St. Francis Alcohol & Drug Abuse Treatment Center
- Substance Abuse Outpatient Therapy
- Youth Assessment

Region 3 Behavioral Health Services
- Professional Partner Program (traditional and transitional age youth and young adults)
- Integrated Care Coordination Unit
- Emergency Community Support
- School-Based Intervention Program

South Central Behavioral Services
- Adolescent Intensive Outpatient
- Mental Health Outpatient Therapy/Assessment
- Substance Abuse Outpatient Therapy/Assessement

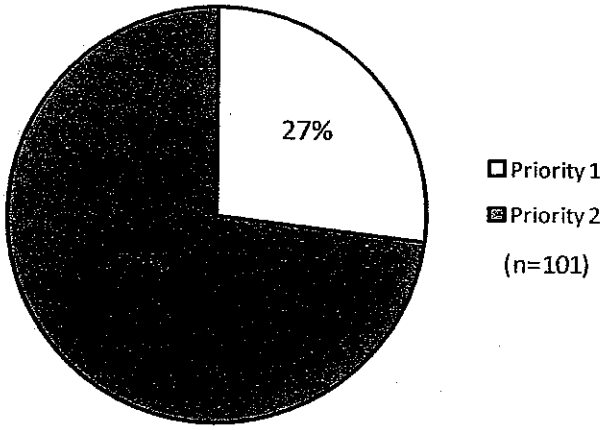
Children's System of Care Expenditures		
Family Empowerment/Youth Leadership	$574,200	7.5%
Contracted Services	$4,256,370	55.8%
Therapeutic Case Management	$2,734,304	35.8%
System Coordination	$65,764	0.9%
TOTAL	$7,630,638	100%

Youth to Adult Transition Team

The transition from youth to adulthood is a time filled with challenges and opportunities that impact individuals well into their future. For young people who experience a behavioral health disorder, the transition process can be met with barriers, lapses in needed services and supports, and times of isolation. The Region 3 Youth to Adult Transition Team (YATT) is designed to offer support to young people and assistance in accessing the services they need to ensure a smooth transition to adulthood. YATT is a collaborative process comprised of local service providers, Region 3 staff and Children and Family Services' staff of the Central Service Area. Referral sources include the Integrated Care Coordination Unit, Professional Partner Program, Children and Family Services Workers, youth serving providers, parents, and youth themselves.

Region 3 Housing Assistance Program

The Region 3 Housing Assistance Program (HAP) provides housing assistance to eligible participants so they may obtain safe and decent housing at an affordable cost. HAP funds serve as a "bridge" to other housing resources or to living independently without any assistance. Eligible participants are adults with extremely low income who have a serious mental illness. These participants are also receiving behavioral health services and have an Individual Service Plan with a goal of independent housing. Funding is used to provide Housing Assistance Vouchers ($5,000 annual cap per voucher) and Housing Flex Funds (annual one-time only payment).



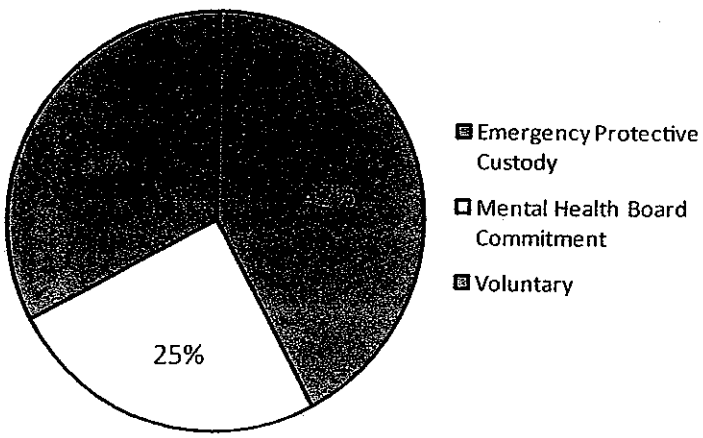
In FY08, the Housing Assistance Program served a total of 101 individuals; 83 received ongoing assistance and 18 received flex funds. A total of 27 individuals (27%) were categorized as Priority 1 participants, which included 21 discharges from inpatient Mental Health Board commitments and 6 discharges from Able House (psych residential rehab). There were 74 individuals (73%) categorized as Priority 2 participants, who were individuals at risk of hospitalization and/or Mental Health Board commitments.

On average an individual spent 53.7 days or 1.79 months on a waiting list before assistance was available, and only 24.67 days between the date assistance became available and the date the first payment was sent. A participant that utilized housing flex funds used an average of $700, one-time only assistance. The Regional Housing Program Coordinator completed 57 Housing Quality Standard (HQS) inspections on apartments in order to determine eligibility for the program; 51 passed inspection the first time, and 6 passed after the second inspection.

Emergency Community Support

The Region 3 Emergency Community Support Program (ERCS) is a voluntary therapeutic case management service providing short-term follow-up services, coordination, and continuity of care to individuals who experience a behavioral health crisis. This short-term program aims to assist adults who are or were in crisis through obtaining the goals of stabilization, independence, and integration into the community, and reducing recidivism in the emergency psychiatric system.

Legal Status at Admission (n=64)



Emergency Community Support served 64 individuals from July 1, 2007 to June 30, 2008. The average length of service for discharged participants was 135.8 days. The average age of the consumer was 35.4 years. 67.2% of the ERCS consumers entered through an Emergency Protective Custody (EPC) and 32.8% entered the ERCS Program through a voluntary admission to a hospital. 74% of the consumers had a discharge plan from ERCS that included at least one informal support and 94.8% had found means to secure medication for one year after discharge from ERCS. ERCS continues to be a valued, timely service supporting consumers and their families through crucial recovery steps.

Integrated Care Coordination Program

Region 3 has a cooperative agreement with the Nebraska Department of Health and Human Services (DHHS) forming a collaborative partnership between Region 3 and the Central Service Area, Division of Children and Family Services. Subsequently, the Integrated Care Coordination Unit (ICCU) has been developed to care for youth who have complex needs and are state wards in Central and South Central Nebraska. The identified youth exhibit high functional impairments in multiple areas (e.g., school, home, community, self-harm, substance abuse). These youth have multiple agency involvement, high service costs and, in which, traditional services alone have failed to produce positive outcomes.

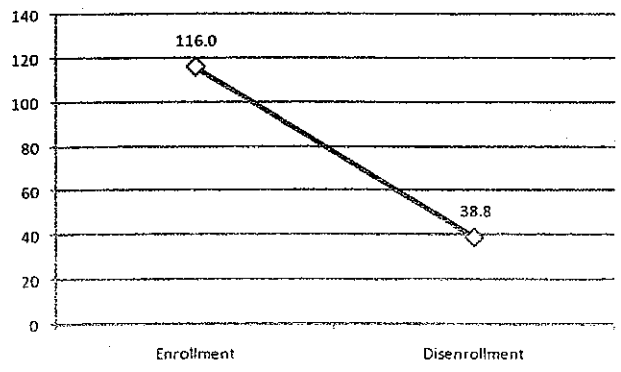
A total of 398 youth were served by the ICCU during FY08, 173 youth were admitted to the ICCU and 170 youth were disenrolled. In addition, 198 siblings were served by the ICCU of which 62 were not state wards, while 136 were state wards. Ages ranged from one month to 18 years of age with the average being 12.1 years. 38.9% of the ICCU youth were girls and 61.1% were boys.

Functional Impairment

The Child and Adolescent Functional Assessment Scale (CAFAS) is used to assess the degree of impairment in youth with emotional, behavioral, and/or substance use symptoms/disorders. Impairment in the CAFAS is defined as problems that interfere with the youth's functioning in various life roles. The CAFAS is arranged in eight subscales for rating the youth: School/Work, Home, Community, Behavior Towards Others, Moods/Emotions, Self-Harmful Behavior, Substance Use, and Thinking. A total score is derived from the summation of the eight subscales. The subscales are rated from severe impairment (30) to minimal or no impairment (0). Scores on the total 8 scale score range from 0 (no problems in any domain) to 240 (major problems on all domains). The youth's most severe dysfunctional behaviors during a three month period are rated.

The graph below compares the total 8 scales CAFAS score for 152 youth who were rated at both enrollment and disenrollment during FY08.

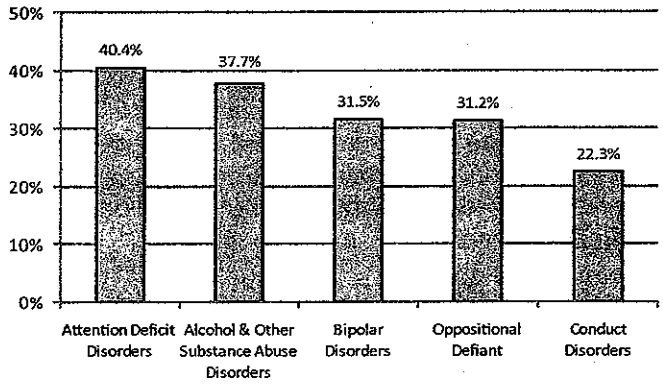
Average Total CAFAS Score
FY08 (n=152)



Diagnosis

73.4% of youth served had a mental health disorder. The graph below lists the five most prominent disorders. Also included are anxiety disorders (18.8%), depressive disorder (18.8%) and others.

Axis I Diagnosis DSM IV-TR
All Youth Served in FY08
(n=292)



Disenrollment

During FY08, 171 youth were disenrolled from the ICCU. In accordance with federal and state statutes, permanency objectives are: family preservation, reunification, adoption, legal guardianship, long-term foster care, independent living, and self-sufficiency with supports. The average length of stay in the program for youth disenrolled was 480.9 days.

Wraparound Fidelity

The Wraparound Fidelity Index (WFI) is collected at six month intervals by Families CARE. The WFI measures eleven core elements of wraparound from the perspectives of parents and youth. The information is based on 205 responses (including 105 parents, 99 youth, and 184 Care Coordinators) who completed the questionnaire with Families CARE staff for July 07 - June 08. The average total adherence score among caregivers, youth and Care Coordinators was 77.4%. The goal for best practice is 80% or higher on the elements of wraparound. Scores falling below 85% are elements that program management will focus on to improve adherence to wraparound.

Satisfaction Surveys

The Family Satisfaction Survey and Youth Satisfaction Survey are collected at 6-month intervals by Families CARE. One hundred thirteen family members had an 83.0% degree of overall family satisfaction and 131 youth had an 81.9% degree of overall satisfaction.

School-Based Intervention

Mission

The mission of the School-Based Intervention Program (SBIP) is to utilize the wraparound principles to develop strength-based, individualized and specific interventions to assist the student in meeting their educational needs and to ensure that each student and family have a voice and ownership in developing their educational goals.

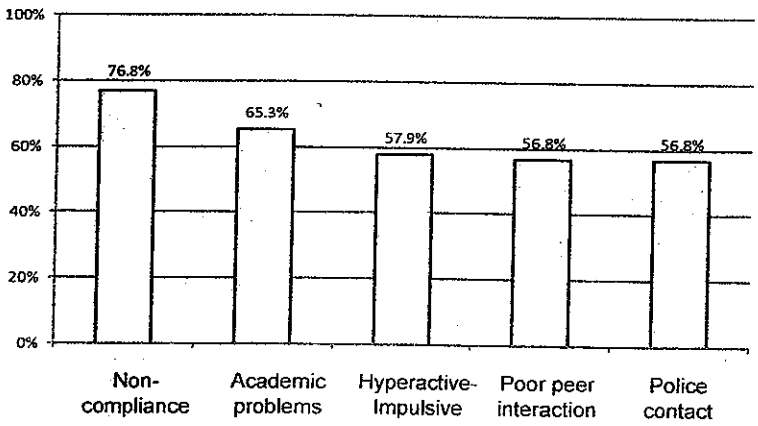
Age

The program served 95 youth in FY08. The average age was 15.9 years old. The majority (93.7%) of youth being served were between 13 and 18 years of age.

Presenting Problems

Youth enrolled often have multiple presenting problems; therefore, the numbers below sum to more than 100%. The following graph dipicts the most commonly cited presenting problems during FY08.

Presenting Problems at Admission of Youth Enrolled in SBIP (n=95)



Care Management Team

The Care Management Team's (CMT) primary function is that of utilization review and management of youth placement. The CMT serves children at risk of being placed out of home and children who are in out of home placement. This involves administering and scoring the initial CAFAS, interviewing caregivers, reviewing the youth's records, including psychological/mental health assessment information, the Youthful Level of Service/ Case Management Inventory completed for the youth in juvenile services; and participating in Child and Family Team meetings when necessary. Additionally, CMT tracks referrals from DHHS and other service providers, determines needed and available support services, and identifies gaps in services. During FY08, 235 youth were referred to the CMT, a 17% increase from the previous year.

During FY08, the CMT reviewed 87 youth referred specifically for the group home level of care. Of the youth referred, all were determined to be appropriate for group home care. In FY08, the CMT reviewed 171 youth in the Central Service Area referred for placement in Agency Supported Foster Care (ASFC). The CMT also reviews each youth placed in ASFC at six-month intervals to ensure the level of care remains appropriate to meet the youth's needs.

During the first half of FY08 the CMT coordinated the Office of Juvenile Services (OJS) evaluations for youth adjudicated in the Central Service Area. After coordination of the clinical portion of the evaluation, the CMT completed a Youth Level of Service/Case Management Inventory for each youth referred and then submitted a recommendation to the court for disposition. From July 1, 2007 through December 31, 2007, the CMT completed 58 OJS evaluations. OJS evaluations were transferred to the Division of Children and Family Services beginning January 1, 2008.

Resource Development Specialist

The Resource Development Specialist (RDS) is responsible for the overall coordination and completion of Home Approvals and Adoption Home Studies for the Integrated Care Coordination Unit and the Central Service Area of the Department of Health and Human Services. Primary responsibilities include: working with Children and Family Services staff and identified families to complete the Home Approval/Adoption Home Study process, complete background checks and roll fingerprints for families, conduct interviews and gather and exchange information related to each individual Home Approval/Adoption Home Study, and prepare written case histories and reports.

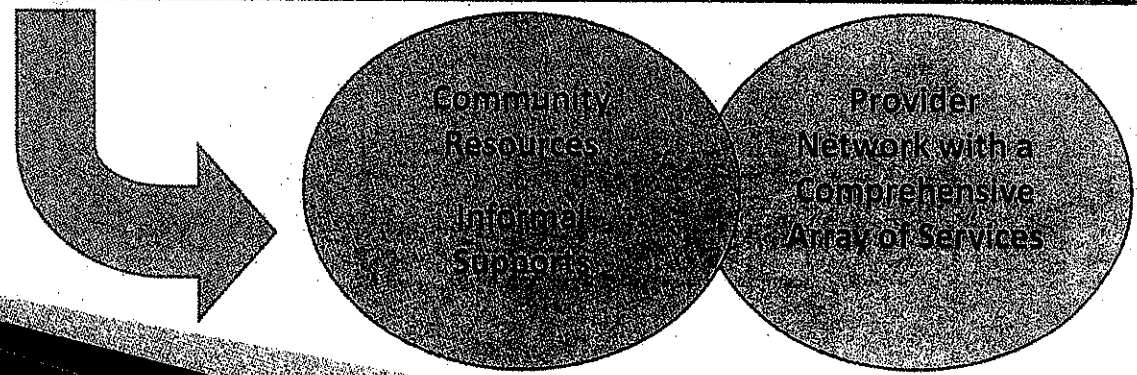
All families that are Approved Homes or Adoptive Homes have the following background checks completed: Nebraska State Patrol, National Criminal History (FBI), Sexual Offender Registry, Department of Motor Vehicle, Adult/Child Protective Services, and Local Law Enforcement. Each adult family member is required to complete a self-study which is a detailed personal history and all families are required to provide five references.

During FY08, the RDS completed 13 Adoption Home Studies and 29 Home Approvals.

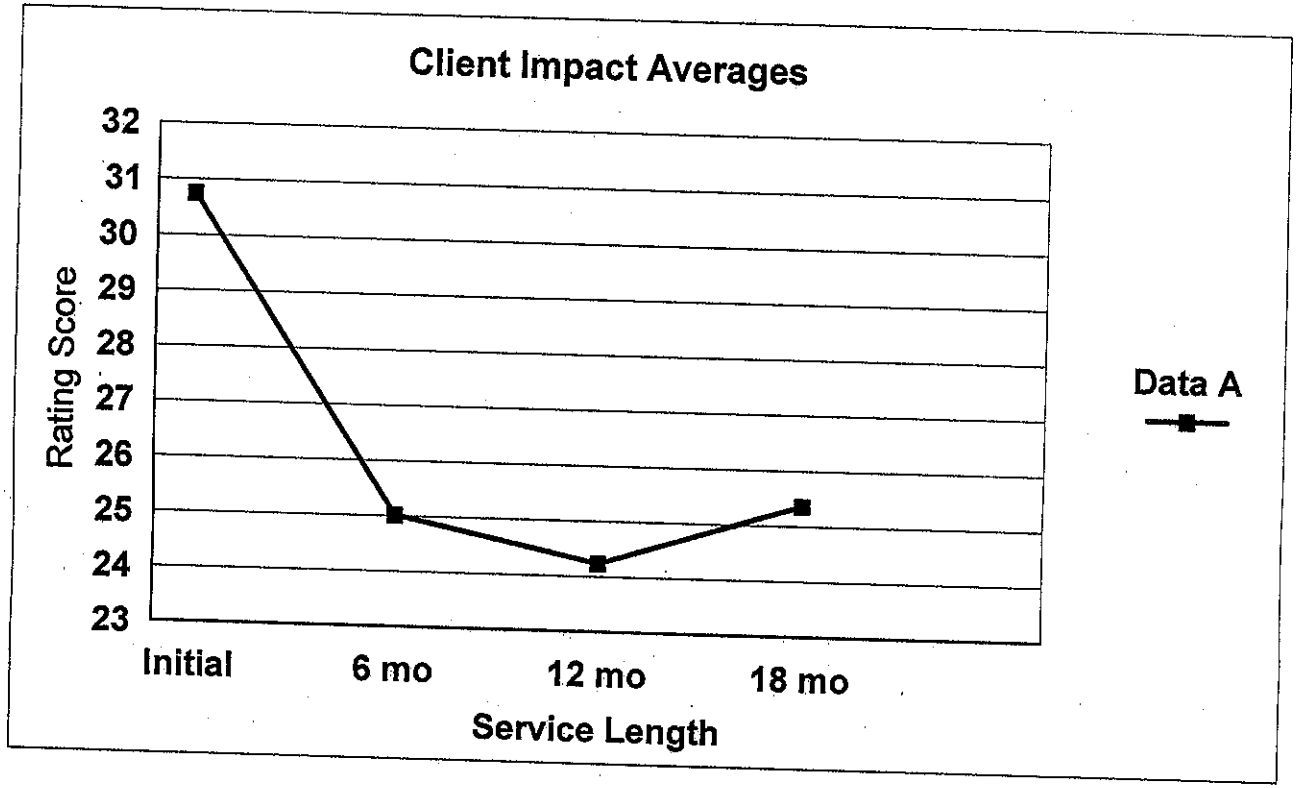
Region 3
Behavioral Health Services

Resource Coordination: Centralized Access Point

1. • Access to information about available resources
2. • Interview process to determine needs
3. • Linkages – assistance to navigate system to access needed services and supports
4. • Follow-up regarding access, needs being addressed, further assistance needed



Measurable Outcomes: The Partner Agencies devised a Service Impact Scale. The scale is comprised of seventeen indices in four categories which track personal, social, situational, and the relative prevalence of deficits. Recipients of service are rated at the onset of service to establish a personal baseline. Comparative ratings are made every six months during the course of service to provide a longitudinal view of progress and service impact.



Region 3
Behavioral Health Services

Projected Number of Youth to be Served during FY 2009

Service Type	Projected Number Served	Allocated Funding
Crisis Services		
Crisis Inpatient	6	19,657
Emergency Community Support - Youth Transition	28	112,309
Middle-Intensity Services		
Professional Partner Program	167	547,500
Professional Partner Program - Youth Transition	28	119,206
Children's Day Treatment	13	58,274
Intensive Outpatient	80	58,479
Multisystemic Therapy (MST)	7	52,136
Outpatient Services		
Outpatient Therapy	186	168,672
Medication Management	20	6,063
Substance Abuse Evaluation/Assessment	25	40,021
System of Care Coordination	NA	70,664
Subtotal NBHS Children's Services	560	$1,252,981
Integrated Care Coordination Unit & Families CARE (Division of Children & Family Services)	790	$3,164,810
Grand Total All Children's Services	1,350	$4,417,791

Health and Human Services Committee
2009 Bills

Tues. Feb 4

Legislative Bills

	Bills	One-liner
1.	**25**	(Friend) Provide for licensure of and Medicaid payments to children's day health services
2.	**27**	(Pahls) Change the Autism Treatment Program Act
3.	**68**	(Wallman) Provide procedures for closure of state residential facilities for persons with developmental disabilities
4.	**84**	(McGill) Eliminate the termination date for the Women's Health Initiative Advisory Council
5.	**91**	(Howard) Provide for a subsidized adoption of a child who was under a subsidized guardianship prior thereto
6.	**132**	(Fulton) Change the Barber Act
7.	**136**	(Avery) Change provisions for eligibility for medical assistance
8.	**141**	(Rogert) Adopt the Brain Injury Act
9.	**146**	(Howard) Provide for simulated pharmacies
10.	**150**	(Heidemann) Repeal the Nebraska Prostitution Intervention and Treatment Act
11.	**172**	(Gay) Change the False Medicaid Claims Act and create a fund
12.	**173**	(Gay) Provide for relabeling and redispensing of prescription drugs at certain correctional facilities
13.	**195**	(Gay) Change the Statewide Trauma System Act
14.	**196**	(Gay) Change loan agreement provisions under the Rural Health Systems and Professional Incentive Act
15.	**198**	(Stuthman) Adopt the Reduced Cigarette Ignition Propensity Act
16.	**214**	(Cornett) Redefine nail technology under the Uniform Credentialing Act

17. **220** (Gloor) Change provisions relating to pharmacy practice and pharmaceuticals

18. **223** (Nantkes) Classify swimming pools and provide operator requirements

19. **226** (Rogert) Change the age of majority to eighteen years of age for certain purposes

20. **230** (Stuthman) Eliminate integrated practice agreements for nurse practitioners

21. **247** (Dubas) Require accreditation of the Division of Children and Family Services of the Department of Health and Human Services

22. **250** (Gloor) Change physician assistant provisions

23. **268** (Lathrop) Require liability insurance as prescribed for child care licensees

24. **275** ✓ (McGill) Require crisis, information, and referral services relating to behavioral health

25. ~~**288**~~ 271 (Health and Human Services Committee) Change provisions relating to health and human services

26. **290** (Stuthman) Require criminal history background checks on individuals who transport vulnerable adults and children under contracts with the Department of Health and Human Services

27. **291** (Lathrop) Require rules and regulations regarding safety, care, and habilitation of persons receiving developmental disabilities services

28. **301** (Gloor) Repeal exemption from fees for medical records

29. **310** (Haar) Change provisions relating to deaf and hard of hearing persons

30. **319** (Speaker Flood) Change provisions relating to child care reimbursement

31. **341** (Cook) Change provisions relating to tuberculosis detection and prevention

32. **342** (Gay) Provide duties for the Department of Health and Human Services relating to payment for pediatric feeding disorder treatment

33. **346** ✓ (Gay) Require the Department of Health and Human Services to provide services relating to children's behavioral health and adoption and guardianship families

34. **356** ✓ (Dubas) Provide behavioral health services for children without parental relinquishment of custody

35. **367** (Gloor) Change health care certificate of need provisions

36. **370** (Nantkes) Require a Medicaid waiver application for family planning services

37. **371** (Campbell) Change Medicaid Reform Plan and Medicaid Reform Council provisions

38. **390** (Coash) State intent regarding reimbursement rates for assisted services for persons with developmental disabilities

39. **394** (Fulton) Define unprofessional conduct for physicians with regard to anatomic pathology services

40. **395** (Fulton) Adopt the Stroke Registry Act

41. **396** (Gloor) Adopt the Medical Home Act

42. **403** (Karpisek) Require verification of lawful presence in the United States to receive public benefits as prescribed

43. **406** (Fulton) Permit certified nurse midwives to have clinical privileges in hospitals

44. **407** (Dierks) Provide civil penalties for engaging in veterinary medicine and surgery without authorization

45. **408** (Dierks) Authorize consultation between veterinarians and other health care professionals

46. **519** ✓ (McGill) Provide for rate increases for behavioral health care providers and create the Provider Reimbursement Rate Commission

47. **540** ✓ (Gay) Change membership of the Children's Behavioral Health Task Force

48. **599** (Howard) Require health care facilities to provide itemized billing statements upon patient's request

49. **601** (Nordquist) Provide for a Medicaid waiver for community-based mental health services

50. **603** (Health & Human Services Committee) Adopt the Behavioral Health

Workforce Act and provide funding

51. **619** ✓ (Howard) Change mental health board membership provisions

Legislative Resolutions

Resolution	One-liner
1. **LR7**	(Fulton) Urge members of Congress to provide that persons enrolling their children in government-sponsored health care plans have certain rights

Attachment 9

NBHS Regional Children's Services Funding FY08-09

DIVISION OF BH
JIA/Rg BH Meeting
FEB 5, 2009

SERVICES	Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Totals	
	Number to be Served	Funding	Number to be Served	Funding	Number to be Served	Funding	Number to be Served	Funding	Number to be Served	Funding	Number to be Served	Funding	Number to be Served	Funding
MH - Children's Services														
Crisis Inpatient - Youth	0	0	0	0	6	19,657	4	17,599	0	0	0	0	10	37,256
ERCS Transition - Youth	0	0	0	0	28	112,309	0	0	0	0	0	0	28	112,309
SUBTOTAL	0	0	0	0	34	131,966	4	17,599	0	0	0	0	38	149,565
MH - Children's Set Aside														
Children's Day Treatment	12	98,084	0	0	13	58,274	0	0	0	0	0	0	25	156,358
Therapeutic Consultation	0	0	15	19,385	0	0	0	0	0	0	0	0	15	19,385
SUBTOTAL	12	98,084	0	0	13	58,274	0	0	0	0	0	0	25	156,358
MH - Professional Partner														
Professional Partner:														
Professional Partner	22	141,890	35	170,270	167	547,500	98	454,054	110	542,001	262	989,114	694	2,844,829
School-Based Professional Partner	14	94,593	0	0	0	0	0	0	0	0	0	0	14	94,593
Youth Transition Program	0	0	0	0	28	119,206	0	0	0	0	0	0	28	119,206
SUBTOTAL	36	236,483	35	170,270	195	666,706	98	454,054	110	542,001	262	989,114	736	3,058,628
MH - Children's Continuation														
Multi Systemic Therapy	0	0	0	0	7	52,136	0	0	0	0	0	0	7	52,136
Med Management - MH	0	0	0	0	20	6,063	5	805	0	0	5	518	30	7,386
Therapeutic Consultation	0	0	0	0	0	0	0	0	24	101,360	0	0	24	101,360
Youth Assessment - MH	0	0	0	0	0	0	0	0	888	143,307	21	3,696	909	147,003
Outpatient Therapy - MH (IndGrpFam)	140	117,870	203	170,303	121	59,179	27	8,439	1,604	390,898	28	31,614	2,123	778,303
Intensive Outpatient - MH	0	0	0	0	0	0	0	0	25	52,829	0	0	25	52,829
Respit Care -MH	0	0	0	0	0	0	10	8,560	0	0	43	45,130	53	53,690
SUBTOTAL	140	117,870	203	170,303	148	117,378	42	17,804	2,541	688,394	97	80,958	3,171	1,192,707
MH-Capacity Access Guarantee	0	0	0	0	See Above	63,505	0	0	0	0	0	0	0	63,505
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

NBHS Regional Children's Services Funding FY08-09

SA - Children's Services		Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Totals
Intensive Outpatient - SA	0	0	0	0	80	58,479	5	30,458	0	0	7	8,849	92	97,786
Youth Assessment - SA	0	0	0	0	25	40,021	20	2,629	244	96,274	29	5,594	318	144,518
Outpatient Therapy - SA (IndGrpFam)	84	50,936	46	131,025	65	30,925	3	1,722	241	146,991	32	24,912	471	386,511
Therapeutic Community	0	0	0	0	0	0	0	0	55	119,643	9	110,388	64	230,031
Community Support - SA	0	0	0	0	0	0	60	126,642	0	0	0	0	60	126,642
SUBTOTAL	84	50,936	46	131,025	170	129,425	88	161,451	540	362,908	77	149,743	1,005	985,488
SA - Capacity Access Guarantee	0	0	0	0	0	15,063	0	0	0	0	0	0	0	15,063
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
REGION SYSTEM COORDINATION														
Region Youth System Coordination	NA	39,430	NA	39,430	NA	70,664	NA	42,502	NA	69,021	NA	62,356	NA	323,403
TOTAL - Children's Services $	**224**	**542,803**	**284**	**530,413**	**560**	**1,252,981**	**232**	**693,410**	**3,191**	**1,662,324**	**436**	**1,282,171**	**4,975**	**5,944,717**

11/1/08 Children's Behavioral Health Task Force (Report from Divisim of BH)

Attachment 10

Planning Recommendations

The task force believes it is important to translate past and present children's behavioral health study and recommendations into specific, meaningful action steps. The recommendations contained in this report are not exhaustive but prioritized in order to sharpen the focus of children's behavioral health planning and to help ensure its successful conclusion and implementation.

The task force is mandated in LB 542 (2007) to consider the following in its behavioral health planning recommendations: (1) a statewide integrated system of care for children and families, including an integrated and comprehensive data and information system;[1] (2) service capacity, including YRTC youth and services provided under Neb. Rev. Stat. §43-406(4);[2] (3) funding;[3] (4) benchmarks and timelines;[4] and (5) legislation.[5] These will form the basis for planning recommendations that follow.

Integrated System of Care

An integrated system of care requires coordination and effective governance, and an active partnership with children and families in all aspects of service planning and delivery. The achievement of a comprehensive and integrated system of care requires the consensus development and adoption of a necessary service array and system integration plan.

Recommendation #1

The task force recommends that the Division of Behavioral Health within the Department of Health and Human Services assume primary responsibility for statewide coordination of the children's behavioral health system. The task force recognizes and applauds the fact that the Director of the Division of Behavioral Health has appointed a children's behavioral health administrator within the division to facilitate such coordination.

After promoting Vicki Maca to the position of Community Services Administrator, Maya Chilese was hire as the Children's Behavioral Health Manager. Ms. Chilese has oversight of the continued efforts to increase the state's youth system coordination.

Recommendation #2

The task force recommends that the Division of Behavioral Health prepare a comprehensive statewide coordination plan for children's behavioral health for the task force's review. Coordination relates to the governance level of the behavioral health system and refers to the cooperative interaction of agencies and organizations charged with various administrative roles and functions within the system. Consistency and responsibility in policy and decision-making is a focal point of planning in this area.

In preparing the plan, the division should consider strategies and mechanisms that will ensure the most effective and efficient long-term coordination and integration of the children's

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[1] See Neb. Rev. Stat. §43-4002(2)(a), (h).
[2] See Neb. Rev. Stat. §43-4002(2)(b)-(d).
[3] See Neb. Rev. Stat. §43-4002(2)(e).
[4] See Neb. Rev. Stat. §43-4002(2)(f).
[5] See Neb. Rev. Stat. §43-4002(2)(g).

behavioral health system, while minimizing the number of quasi-governmental advisory and other bodies for which the division is accountable. The division should form a temporary interagency working group for the development of an initial consensus on system coordination issues, concerns, and solutions.

The Division of Behavioral Health, DHHS prepared and presented the "Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families" Implementation Plan pursuant to the LB 542 on January 4, 2008

Recommendation #3

The task force recommends that the Division of Behavioral Health, in consultation with the task force, develop a proposed system integration plan for the children's behavioral health system that, in its opinion, will most effectively meet the needs of children and adolescents with behavioral health disorders and their families. Integration relates to the broader functioning of the children's behavioral health system and refers to the simplified and efficient interrelationship of all the persons, processes, and organizations involved in the delivery and funding of behavioral health services to children and their families.

The Division's recommended Implementation Plan included a description of the proposed integration. In addition the Children's Behavioral Health Manager and representative of the Division of Medicaid and Long Term Care and the Division of Children and Family Services meet regularly to strengthen integrated approached to children's behavioral health care.

Recommendation #4

The task force recommends that the Division of Behavioral Health, in consultation with the task force, develop a data and information proposal for the children's behavioral health system that, in its opinion, will most effectively enhance integration, access, and quality of behavioral health services provided to children and families and provide meaningful accountability evaluation mechanisms for the children's behavioral health system.

The Division of Behavioral Health, the Division of Medicaid and Long Term Care and the Division of Children and Family Services have jointly contracted with and Administrative Service Organization effective July 1, 2008. This will increase the ability of service management and information sharing.

Capacity

An accurate assessment of need provides the basis for the identification and development of appropriate service capacity. Service capacity includes a full continuum of behavioral health services supported by adequate and sustainable funding. The development of appropriate service capacity requires coordinated planning and implementation and the effective recruitment and retention of behavioral health providers.

Recommendation #5

The task force recommends that the Division of Behavioral Health conduct a more comprehensive statewide analysis of child and adolescent behavioral health needs and current

service capacity, in partnership with local public health departments, regional behavioral health authorities, family organizations, county government, providers, and others. The task force realizes that various surveys and assessments have been conducted, and intends that this analysis build upon and enhance those previous efforts. The task force recommends that the cost of the analysis be paid from a variety of sources, including but not limited to, Nebraska Health Care Cash Funds

The reporting collected by the jointly utilized ASO contract will greatly assist the Division's data collection and analysis in order to better assess current service capacity.

Recommendation #6

The task force recommends that the Division of Behavioral Health, in consultation with the task force, prepare a proposed capacity development plan for the children's behavioral health system. The task force believes that the formation of a capacity development plan for children's behavioral health services should be based upon the statewide analysis of behavioral health needs and service capacity referenced above.

The Division's recommended Implementation Plan included a description of the current service delivery system and the desired service array. Action is being pursued through the collaborative efforts of the State Infrastructure Grant (SIG) and the three above mentioned DHHS Divisions.

Recommendation #7

The task force recommends the establishment and implementation of a multidisciplinary and collaborative effort for behavioral health education to focus ongoing resources on the statewide recruitment, training, deployment, and retention of a broad spectrum of providers of children's behavioral health services and supports, including peer-provided and family support services. The task force recommends the enactment of necessary and appropriate legislation in 2008 to establish such an initiative.

The SIG Steering Committee has a broad membership meeting this as well as federal criteria. This SIG committee with officially end in September 2009 with the grant conclusion, but may continue in the shape of a Children's Behavioral Health Committee yet to be determined.

Recommendation #8

The task force recommends that residential adolescent mental health services at the Hastings Regional Center be discontinued, and transferred to appropriate community-based providers. On October 23, 2007, the Division of Behavioral Health Services provided notice of its intent to reduce capacity for adolescent residential psychiatric services at HRC from 16 beds to 8 beds. On that date, there were two youth receiving such services at HRC. Any reduction or discontinuation of regional center services must comply with relevant provisions of Neb. Rev. Stat. 871-810.

The Hastings Regional Center residential adolescent mental health services discontinued service provision as of January 1, 2008.

Recommendation #9

The task force recommends that the Office of Juvenile Services within the Department of Health and Human Services adopt necessary and appropriate changes to ensure that all YRTC youth with behavioral health needs are appropriately assessed. The task force recommends that the office diligently pursue alternatives to the referral of YRTC-Kearney youth to the Hastings Regional Center for residential substance abuse treatment whenever possible and appropriate. This action is the ongoing responsibility of the Division of Children and Family Services, Office of Juvenile Services, and YRTC youth are receiving assessments of their needs upon entry into the facility.

Funding

The allocation and expenditure of funding for children's behavioral health services must be integrated, diversified, flexible, effective, and efficient. The task force believes that relevant provisions of the Nebraska Behavioral Health Services Act relating to funding should be more aggressively pursued and expanded.

Recommendation #10

The task force recommends that the Chief Executive Officer of the Department of Health and Human Services (department) be responsible for the development of a behavioral health funding integration proposal that comports with provisions of Neb. Rev. Stat. §71-811 and includes "all funds appropriated by the Legislature or otherwise received by the department from any other public or private source for the provision of behavioral health services."[6]

The proposal should clearly identify all current behavioral health funding sources received by the department, the current policies and procedures governing the allocation and expenditure of such funds, an evaluation of the efficiency and effectiveness of such policies and procedures, and the development of alternative strategies and mechanisms to achieve a more simplified, integrated, and effective expenditure of behavioral health funding for children and adolescents. The task force recommends that the funding integration proposal be completed no later then June 30, 2008.

The task force recommends that the Director of the Division of Behavioral Health immediately ascertain and provide for the reallocation and expenditure of Hastings Regional Center funding associated with HRC services that have been reduced or discontinued pursuant to Neb. Rev. Stat. §71-810 "for purposes related to the statewide development and provision of community-based services."[7]

The joint contract within DHHS between the three Divisions with one ASO as well as the work of the State Infrastructure Grant has greatly increased the collaborative efforts of behavioral health service delivery, integration and assessment.

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[6] See Neb. Rev. Stat. §71-811.

[7] Neb. Rev. Stat. §70-810 provides, in part, ". . . (4) As regional center services are reduced or discontinued under this section, the division shall make appropriate corresponding reductions in regional center personnel and other expenditures related to the provision of such services. All funding related to the provision of regional center services that are reduced or discontinued under this section shall be reallocated and expended by the division for purposes related to the statewide development and provision of community-based services. . . ."

Recommendation #11

The task force recommends the adoption of behavioral health insurance parity legislation. The task force recognizes that federal congressional action is currently pending on the issue and believes that such efforts should be closely monitored. The task force encourages the introduction and passage of state behavioral health insurance parity legislation if necessary and appropriate.

This is a policy decision for the legislature to deliver.

Recommendation #12

The task force recommends that the Division of Medicaid and Long-Term Care and the Division of Behavioral Health within the Department of Health and Human Services conduct an assessment and re-procurement of the current administrative services contacts with Magellan Behavioral Health. The task force recommends that such assessment and re-procurement be conducted as expeditiously as possible and completed no later than June 30, 2008.

After a RFP process, the Division of Behavioral Health, the Division of Medicaid and Long Term Care and the Division of Children and Family Services jointly contracted for an Administrative Service Organization for the fiscal year of 2008-09; Magellan was the awarded vendor.

* Note, the Progress Report is missing Recommendation #13 from the original report

Recommendation #13

The task force recommends that the Division of Behavioral Health and the Nebraska Legislature develop and implement administrative and legislative strategies and mechanisms to reduce the number of instances in which parents seek to have their children placed in the custody of the Department of Health and Human Services in order to access needed services.

Legislation

Recommendation #13

The task force recommends that Senator Johnson, as chair of the Health and Human Services Committee of the Legislature, oversee the preparation and introduction of necessary and appropriate legislation consistent with the foregoing recommendations, including but not limited to: (1) amendments to statutes relating to the Children's Behavioral Health Task Force; (2) amendments to the Nebraska Behavioral Health Services Act relating to the provision of children's behavioral health services; and (3) legislation to establish and fund a collaborative and multidisciplinary initiative focusing on the statewide recruitment and retention of behavioral health providers.

This item is the recommended responsibility of Senator Joel Johnson by the Task Force.

Recommendation #14

The task force recommends that the Health and Human Services Committee of the Legislature, in consultation with members of the Judiciary Committee of the Legislature, and other interested parties, review relevant provisions of the Nebraska Juvenile Code and the Health

and Human Services, Office of Juvenile Services Act to identify and prepare necessary and appropriate statutory changes for consideration by the Legislature in 2009.

This item is the responsibility of the Health and Human Services Committee of the Legislature.

Benchmarks and Timelines

Recommendation #15

The task force recommends and urges that the planning activities and recommendations contained in this report be pursued as expeditiously as possible and that the department include specific timelines for such activities in its plan submitted on or before January 4, 2007.[8] The task force requests that the Division of Behavioral Health provide quarterly progress reports to the task force beginning in January 2008.

The DHHS Implementation Report presented on January 4, 2008 incorporatied activities and timelines including the work plan of the State Infrastructure Grant and further implementation is ongoing.

Recommendation #16

LB 542 (2007) requires the Department of Health and Human Services to provide a written implementation and appropriations plan by January 4, 2008, based on the task force's report.[9]

The task force recommends that the department include specific timelines for completion of activities identified in the plan. The task force recommends that the chair of the task force be empowered to establish subcommittees of the task force as necessary and appropriate, in consultation with the task force and the department, to facilitate the further development and implementation of the plan submitted by the division.

The DHHS prepared and presented this document by January 4, 2008.

[8] Neb. Rev. Stat. §43-4002(2) (Laws 2007, LB 542, §2).
[9] Neb. Rev. Stat. §43-4002(2) (Laws 2007, LB 542, §2).

Alternatives 2009

(the 23rd annual Alternatives conference)
– the only national mental health conference organized by and for people diagnosed with mental illnesses –
will be held
Wednesday, October 28, 2009,
through Sunday, November 1, 2009,
at the Hilton Omaha in Omaha, Nebraska.

Each Alternatives conference offers in-depth technical assistance on peer-delivered services and self-help/recovery methods. Beyond the exchange of knowledge and networking, Alternatives offers a rich social, artistic, and healing environment. Said one attendee, "The conference transformed me so I can transform the system."

Mark your calendars!

RE: PATH

Attachment 12

SUMMARY – Voluntary Programmatic Performance Goals

Under the Projects for Assistance in Transition from Homelessness (PATH) Program

VPG Goal 1: State focuses provider operation to serving literally homeless individuals.

- PATH has an important role to play regarding community plans to end chronic homelessness.
- There is a community benefit to data consistency between PATH and the Continuum of Care systems. HUD has required implementation of a Homeless Management Information System by October of 2004 and PATH can participate only to the extent that the definitions are consistent.
- NOTE: The NE PATH should use the same definitions as used in the NE Homeless Assistance Program.

VPG Goal 2: Active state management and oversight of the PATH program.

- State leadership of PATH requires active management and oversight.
- Use of a competitive renewal process for PATH providers
- Active management also means:
  - Dollars and funded programs match with the pattern of need/unmet need in the state.
  - State leadership adjusts provider performance to knowledge about emerging best practices.
  - State leadership adjusts provider performance to new information about chronic homelessness.

VPG Goal 3: State provides specific guidance and oversight to providers regarding reporting and definitions.

(This could be a function of Active Management, above)

- The basic principle is state control of definitions.
- The state PATH contact's role is to understand how providers are counting and reporting numbers of people receiving outreach services, numbers of people enrolled in the PATH program, and a full array of data elements about the individuals who receive services. Examples of "working definitions"
  - **Outreach:** PATH staff approach homeless individuals, offer assistance, and informally assess eligibility for PATH services (i.e., mental illness, co-occurring disorders). NOTE: For the formal service definition of outreach, please see PATH National Definitions at www.pathprogram.samhsa.gov.
  - **Engagement:** PATH staff attempt to persuade eligible individuals to accept ongoing or more intensive services.
  - **Enrollment:** Individuals are PATH eligible, are willing to accept ongoing services from the PATH worker, and have presented sufficient identifying information to create a formal record.
  - **Transition to Mainstream Services:** Individuals enrolled in PATH make a formal change to housing and services funded through programs such as Section 8, Medicaid, public health, MH/SA Block Grant, etc.

VPG Goal 4: State leadership fosters the use of exemplary practices at provider sites.

- Effective PATH programs are using tried and true techniques.
- Exemplary practices are activities that are evidence-based, are considered promising practices, are unique or creative responses to specific conditions are successful in bridging gaps or meeting unmet need, or any other exemplary set of actions that can be identified and observed.
- Examples of exemplary practices include:
  - Involvement in the Continuum of Care Planning Process.
  - Outreach to people who are chronically homeless
  - Strategic Partnerships (such as state/local partnerships with criminal justice or housing agencies)
  - Use of evidence based practices by PATH programs

VPG Goal 5: State leadership actively supports transition to mainstream services activities.

- PATH programs frequently serve as the front door to the mainstream mental health system.
- Mental Health Mainstream Services may include:
  - Services provided by community mental centers or veterans' services centers
  - Services available through private mental health providers
  - Mental health services provides by general practitioners or clinics
  - Housing Mainstream Services such as Permanent supportive housing programs
  - Mainstream Resources such as Medicaid / Medicare, Social Security benefits, Food Stamps

Measurement of Voluntary Performance Goals

5 = Strong evidence of significant state activity in this area (documentation plus field observation)
4 = Evidence of significant state activity in this area (documentation and/or field observation)
3 = State PATH contact aware of issue, no action being taken at this time, may be in the planning or investigative stages.
2 = No action being taken and none planned.
1 = State does not agree with voluntary criteria and does not intend to adjust performance.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 5, 2009

Article I – Name of Organization

The name of the organization shall be the State Advisory Committee on Mental Health Services.

Article II – Purpose

Section 1
As provided by Nebraska Revised Statutes section 71-814 the purpose of the Committee is to (1) serve as the state's mental health planning council as required by Public Law 102-321, (2) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, (3) promote the interests of consumers and their families, (4) provide reports as requested by the division, and (5) engage in such other activities as directed or authorized by the Division. Division means Behavioral Health Services.

Section 2
MISSION STATEMENT
The Mission of Nebraska State Advisory Committee on Mental Health Services is to identify and advocate for an effective and efficient system of accessible, quality mental health services which enable each individual, on their journey of healing and transformation, to achieve their highest potential.

VISION STATEMENT
The Vision of Nebraska State Advisory Committee on Mental Health Services is to advise and assist the Division as it provides information for all Nebraskans, including consumers, families and the public to understand mental health problems, and to provide the knowledge necessary to access and utilize appropriate services in a timely, effective manner.

Article III – Membership

Section 1
Appointments: The committee shall consist of twenty-three members appointed by the Governor.

~~**Section 2**~~
Length of Term: The length of term ~~for members is three years. As the terms of the initial members expire, their successors shall be appointed for terms of three years~~. As appointed by the Governor.

Section 3
Attendance: A member who has two consecutive unexcused absences shall be contacted by the Division of Behavioral Health ~~Chairperson~~ regarding his/her intentions for future participation in the Committee. If the person indicates he/she is not able to participate, the ~~Chairperson~~ the Division of Behavioral Health shall request he/she formally resign from the Committee. Formal resignation shall be in writing and is to be submitted to the Director of the Division of Behavioral Health ~~Health and Human Services~~. ~~HHSS~~ Division of Behavioral Health staff will maintain attendance sheet and submit to Chairperson periodically or per request.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 5, 2009

Article IV - Voting

Section 1
Quorum: A quorum shall consist of one member more than half of the current members of the Committee Once established, a quorum shall be deemed to continue throughout the meeting. All Committee business shall be conducted by a simple majority vote of members present at a meeting in which a quorum is established.

Section 2
Conflicts of Interest: A conflict of interest is created through the existence of circumstances where the actions of a member may have an effect of direct financial benefit or detriment to the member, a member of his/her family, employer, business associate, or a business in which the member owns a substantial interest. As soon as the member is aware of a potential conflict of interest (or should reasonably be so aware), the member shall complete the Potential Conflict of Interest Statement Form C-2. The Form shall be submitted to the Nebraska Accountability and Disclosure Commission. The member shall follow all directions as prescribed and advised by the Nebraska Accountability and Disclosure Commission. If a dispute arises as to whether a conflict exists, the chairperson shall direct that the member's vote be disregarded on a given issue until such time as the member is in possession of a written opinion from the Nebraska Accountability and Disclosure Commission. Meeting minutes shall record the name of a member(s), who abstains from voting.

Article V – Officers

Section 1
Selection: Officers of the Committee shall be a Chairperson, Vice-Chairperson and Secretary. (In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.) this to be moved to Section 3 on page 3

Section 2

Duties: The duties of the Officers shall be:

Chairperson – Preside at all Committee and Executive meetings and:

(1) Attend annual technical assistance meeting on MH Block Grant
(2) Represent Nebraska at the MH Block Grant application review
(3) Write a letter representing the committee's point of view after reviewing the MH block grant application, to be attached and is due September 1.
(4) Write a letter after reviewing Mental Health block grant implementation report due December 1
(5) Perform any other duties designated by the Committee.
(6) Review attendance report and contact members as needed.

Vice-Chairperson - Shall act for the Chairperson in his/her absence. Shall perform other duties as designated by the Chairpersons or Committee

Secretary – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairpersons or Committee

Section 3
~~**Term**: No officer shall serve more than three consecutive one-year terms.~~ At the fall meeting the committee will select officers for one year. The new officers term are January 1 through December 31.

Section 4
Executive Committee: The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Secretary. A Chairperson may call the Executive Committee together with the approval of the Division, at his/her discretion.

Article VI - Meetings

Section 1
Frequency: Meetings of the Committee shall be held regularly.

Section 2
Conduct: Meetings shall be held in accordance with the requirements of the Nebraska Public Meetings Law, Neb. Rev. Stat. sections 84-1408 through 84-1414. Business should be conducted according to Roberts Rules of Order.

Section 3
Notice: The time, date and location of the next meeting should be determined prior to adjournment of the preceding meeting. Notification of the time, date and location of the next meeting shall be sent within two weeks to all members absent from the preceding meeting. Within thirty days, but not less than seven days prior to the next meeting, the Division shall mail a written reminder and meeting agenda to each Committee member at his/her last known official address.

Section 4
Duties of the Division: The Division of Behavioral Health Services shall provide an orientation to each new Committee member, produce meeting minutes, maintain records to include attendance record of the Committee, and provide ~~Secretarial~~ support to the Committee.

Section 5
Expenses: Committee members shall be reimbursed for actual and necessary expenses in the performance of their duties as provided in Neb. Rev. Stat.sections81-1174 to 81-1177.

Article VII - Committees

With the written approval of the Division, the Chairperson may appoint or otherwise establish ad-hoc task forces comprised of Committee and non-committee members to accomplish a specific task which is relevant to the purpose of the Committee. Ad-hoc Committee is defined as including committee and non-committee members.

Article VIII – Amendments

There shall be a review of the Bylaws a minimum of every three years. A two-thirds majority vote of all Committee members will be required to amend the Bylaws. No Bylaws shall be considered for amendment unless notice of the same shall have been established as part of the meeting agenda, and a copy of the proposed changes has been mailed to members within thirty days, but not less than seven days, prior to the meeting at which the vote will take place.

All alterations, amendments, or new by-laws adopted by the Committee are subject to the approval of the ~~Administrator of the Behavioral Health Services Division~~ Director of the Division of Behavioral Health or the designated representative for the ~~Administrator~~ Director.

Revised:
August 7, 2007
February 5, 2009 (reviewed by Committee)

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 5, 2009

Nebraska Revised Statute 71-814
State Advisory Committee on Mental Health Services; created; members; duties.

State Advisory Committee on Mental Health Services; created; members; duties. (1) The State Advisory Committee on Mental Health Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows: (a) One regional governing board member, (b) one regional administrator, (c) twelve consumers of behavioral health services or their family members, (d) two providers of behavioral health services, (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, (f) three representatives from the Department of Health and Human Services representing mental health, social services, and medicaid, (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.

(2) The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division.

Source

1. Laws 2004, LB 1083, § 14;
2. Laws 2006, LB 994, § 93;
3. Laws 2007, LB296, § 460.

STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES

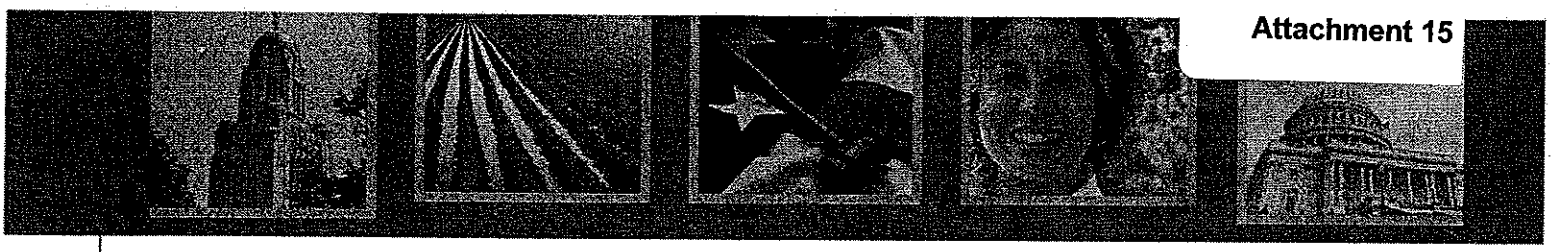
Membership Term and Appointment

Current as of 7/22/2008 dates reviewed by ac 1-7-09

Last Name	First Name	Statutory Requirement	Term	Current Appointment date
Bace	Adria *	Dept. of Education/Special Populations	7/14/08 – 7/1/11	July 14, 2008
Baxter	Beth	Region 3 Administrator	10/17/07 – 7/1/10	October 17, 2007
Burke	James (Jimmy)	Consumer/Region 5	7/14/08 – 7/1/11	July 14, 2008
Chesen	Dr. Chelsea	Provider/Region 6	12/11/07 – 7/1/10	December 11, 2007
Cillessen	Roxie*	DHHS Medicaid	10/17/07-7/1/09	October 17, 2007
Compton	Pat*	Housing Office-Dept of Econ Dev	7/14/08 – 7/1/11	July 14, 2008
Crouse	Cheryl	Consumer/Region 3	7/14/08 – 7/1/11	July 14, 2008
Ferguson	Beverly	Family member of Child w/SED/Region 4	011/28/06 – 7/1/09	November 28, 2006
Ford	Scot	Commission on Law Enforcement & Criminal Justice Rep./South Sioux City Police Chief	11/28/06 – 7/1/09	November 28, 2006
Fowler	Dwain	Family member Adult w/SMI/Region 3	7/14/08 – 7/1/11	July 14, 2008
Hall	Joleine	Consumer/Region 1	11/28/06 – 7/1/09	November 28, 2006
Hanus	Chris*	Social Services/Protection & Safety - Child Welfare, Domestic Violence	10/17/07 – 7/1/10	October 17 2007
Hawkins	Clint	Family member Child w/SED/Region 4	07/01/08 – 07/1/10	July 1, 2008
Hecht	Morgan	Provider/Region 6	10/17/07 – 7/1/09	October 17, 2007
Krome	Susan	Family Member of Adult with SMI/Region 5	7/14/08 – 7/1/11	July 14, 2008
Lewis	Kathy	Family Member of Adult with SMI/Region 4	7/14/08 – 7/1/11	July 14, 2008
Lloyd	Frank*	Vocational Rehabilitation	10/17/07 – 7/1/10	October 17, 2007
Manthei	Colleen	Family Member of Child w/SED	11/28/06 – 7/1/09	November 28, 2006
McCallum	Jerry	Regional Governing Board – Region 4	11/28/06 – 7/1/09	November 28, 2006
Maca	Vicki*	Admin-Div of Behavioral Health Services	06/12/08 – 06/12/11	June 12, 2008
Talbott	Pat	Consumer/Region 5	11/28/06 – 7/1/09	November 28, 2006
Waggoner	Dianna	Family Member of Adult with SMI/Region 6	7/14/08 – 7/1/2010	July 14, 2008
Byers	Leslie	Family Member of Adult with SMI/Region 6	7/14/08 – 7/1/2010	July 14, 2008

*APOG (at the pleasure of the Governor)

Alex H: MH Committee Terms updated 1/7/09



Attachment 15

Nebraska Justice Behavioral Health Initiative Strategic Plan

October 31, 2008

Complete report on Division of Behavioral Health web site at:
Division of Behavioral Health: Community-based Services
Recent Reports

http://www.dhhs.ne.gov/beh/NEJusticeMHStrategicPlan-UN_PPCFinalReport-Oct31_2008.pdf

SUMMARY – NE Division of Behavioral Health Application for
U.S. Department of Justice – Bureau of Justice Assistance (BJA) Grant
Justice and Mental Health Collaboration Program (CDFA #16.745)
CATEGORY II: PLANNING AND IMPLEMENTATION

- Submitted on May 6, 2008 … Award with Project Period: 11/01/2008 to 10/31/2011
- Grant maximum: $250,000 ($100,000 year one; $100,000 year two; $50,000 year three)
- NE Theme: collaborative partnerships to address interagency coordination & communication in order to implement system improvements for persons with MI in the Criminal Justice System.
- Target Population: Young adults 18 to 24 years of age.

Goal 1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams.

Objectives:
- 1.1 Build on CIT training curriculum and adapt for rural areas and various professions (parole, probation, jail personnel, etc.)
- 1.2 Pilot comprehensive CIT train the trainers training. Trainers will train 20 law enforcement officers in one community
- 1.3 Study impact of pilot project
- 1.4 Implement statewide CIT training for law enforcement
- 1.5 Adapt CIT training curriculum for probation and parole
- 1.6 Pilot CIT train the trainers training for probation and parole and expand statewide

Goal 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers.

Objectives:
- 2.1 Refine model for crisis intervention for transition aged youth through consultation with national expert.
- 2.2 Pilot model for crisis intervention coordination in one community based on local plan for 100 – 200 individuals
- 2.3 Study impact of crisis intervention pilot
- 2.4 Implement crisis intervention model statewide
- 2.5 Implement strategies for sustaining crisis programs

Goal 3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services.

Objectives:
- 3.1 Refine plan for standardized screening and assessment process
- 3.2 Incorporate processes into Nebraska jail standards
- 3.3 Develop and provide training and technical assistance for jail personnel
- 3.4 Evaluate impact of change in standards

Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management.

Objectives:
- 4.1 Adopt lessons learned from Nebraska's two urban jail diversion programs to develop a rural model
- 4.2 Pilot rural jail diversion program for transition aged youth in one area of the state in coordination with crisis response teams
- 4.3 Examine service definitions for community support/case management and examine financing approaches for sustainability
- 4.4 Study impact of jail diversion pilot
- 4.5 Implement coordinated jail diversion programs in other areas
- 4.6 Implement strategies for sustaining jail diversion programs through 2009 – 2010 contracts

Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.

Objectives:
- 5.1 Collaborate with Nebraska's Action Plan For Increasing Access to Mainstream Services for Persons Experiencing Chronic Homelessness to identify individuals in Department of Correctional Facilities with mental illness ready for release
- 5.2 Develop protocols for developing housing plan and linking individuals with supported housing and supported employment including assessing for Medicaid eligibility
- 5.3 Pilot protocols in Omaha area for 250 transitioning young adults
- 5.4 Provide Rent-Wise Education for 150 consumers in Omaha area

Nebraska 2008 Behavioral Health Consumer Surveys
Summary of Results

Methodology

In 2008, the Department of Health and Human Services' (DHHS) Division of Public Health, Data Management Unit, under contract with the Division of Behavioral Health Services ("the Division"), conducted the Behavioral Health Consumer Surveys. [1]

The survey instruments used for the behavioral health consumer surveys were designated by the Center for Mental Health Services to meet the Federal Community Mental Health Services Block Grant, Uniform Reporting System requirements for Table 9: Social Connectedness & Improved Functioning and Table 11: Summary Profile of Client Evaluation of Care. This instrument consists of the ***28-Item Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey*** (augmented with 11 questions on improved functioning and social connectedness), the ***MHSIP Youth Services Survey (YSS)***, and the ***MHSIP Youth Services Survey for Families (YSS-F)***.

The sample for the surveys was persons receiving mental health and/or substance abuse services from the Nebraska Behavioral Health System, a statewide network of publicly funded community-based mental health and substance abuse providers. The Division sent a list of names and addresses of current mental health/ substance abuse consumers to the DHHS Division of Public Health's Data Management Unit. The Unit subcontracted with a private company to take the list of names and addresses and provide phone numbers for the consumers on the list.

The Division contracted with the Data Management Unit to conduct the phone interviews and to enter the responses from the phone and mail surveys into a database. Data from the surveys were compiled and analyzed by the Research and Performance Measurement unit in DHHS – Financial Services - Operations.

A letter to the consumer was prepared by the Division which introduced the survey and explained how the Unit would be contacting the consumer by phone over the next few weeks. The phone number of the consumer was included in the introductory letter. The letter was sent by the Unit to the consumers in the sample, providing the consumer with three options: 1) to be interviewed over the telephone by a professional interviewer; 2) to be sent a mail survey; or 3) to decline participation in the survey. The consumer was given a toll-free number to indicate their choice to participate, by phone or mail, or to decline participation. If the consumer did not respond to the letter, they were contacted by phone, when they were again given an opportunity to decline participation.

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[1] Questions regarding the 2008 Behavioral Health Consumer Surveys should be directed to Jim Harvey, Nebraska Department of Health and Human Services, Division of Behavioral Health at: 402-471-7824 or email: jim.harvey@nebraska.gov.

Interviewers for the Behavioral Risk Factor Surveillance System (BRFSS) were used to conduct the telephone interviews. For those consumers electing to be interviewed over the phone, BRFSS interviewers attempted each phone number up to 15 times. (After the 15th unsuccessful attempt, the consumers' name was dropped from the list.) Consumers electing to receive a mail survey were sent a survey. If they did not respond within the designated time, they were sent a follow-up survey.

Of the 5,980 persons in the adult sample, some refused to participate. An incorrect or non-working telephone number, or an incorrect address, had been provided for a significant number of consumers, so they could not be contacted. In all, 1,019 adult consumer surveys were completed, a 13% decrease from 2007. (The confidence interval for the Adult survey was +/- 3% at the 95% confidence level.) Of the 784 youth (or parents) in the sample, 128 completed the survey, down 50% from 2007. (The confidence interval for the Youth survey was +/- 9% at the 95% confidence level.) Again, incorrect telephone numbers or addresses were a major issue for the Youth survey.

Survey Results

Adult Survey

A little over half (51%) of the adult respondents were male. The respondents ranged in age from 18 to 81, with an average age of 40 years. Most were White (85.4%), followed by Black/African American (4.3%), and American Indian (2.9%). About five percent were Hispanic or Latino.

Survey data were analyzed by race, gender and age. In addition, the responses for multiple questions were combined into the following seven scales or "domains" (see Appendix A for the questions included in each scale, an explanation of the calculation of scale scores, and information on scale reliability):

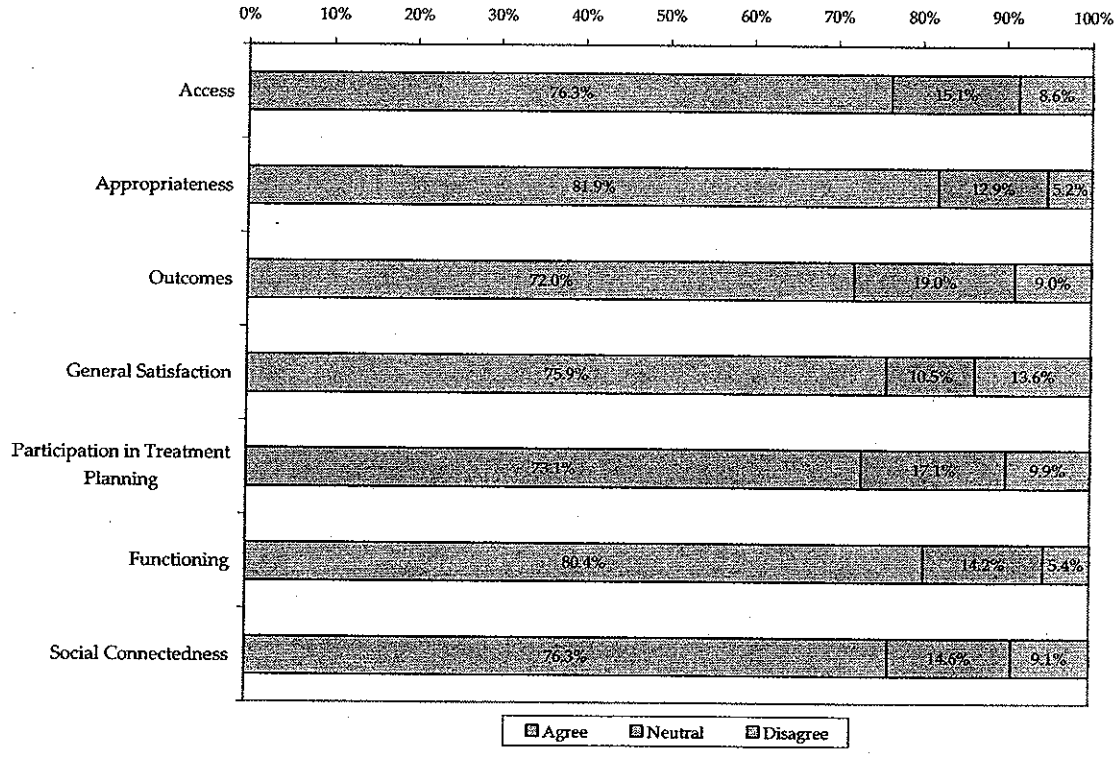
- Access
- Quality and Appropriateness of Services
- Outcomes
- Participation in Treatment Planning
- General Satisfaction
- Functioning
- Social Connectedness

Summary of Results – Adult Survey

Generally speaking, consumers appeared to be satisfied with the services they received. In the area of General Satisfaction, most adult respondents (76%) were satisfied with services (Figure 1). About 14% percent were dissatisfied with services, and 10% were

neutral. About three-fourths (73%) were satisfied with their level of involvement in treatment planning. Nearly three-fourths (72%) responded positively about outcomes. Almost 82% responded positively to the questions related to the quality and appropriateness of services, and more than 76% thought that the services were accessible.

Figure 1
Statewide Summary – MHSIP Scales – Adults



Men responded more positively than women on all seven scales, although none of the differences were statistically significant. There were also no significant differences between responses between White, non Hispanic adults and Non-White or Hispanic adults (see Tables 1 and 2 in Appendix B). Older persons (aged 65 and over) responded significantly more positively to questions regarding **Outcomes** than persons 45-64 years of age. Otherwise, there were no significant differences in scale scores by age.

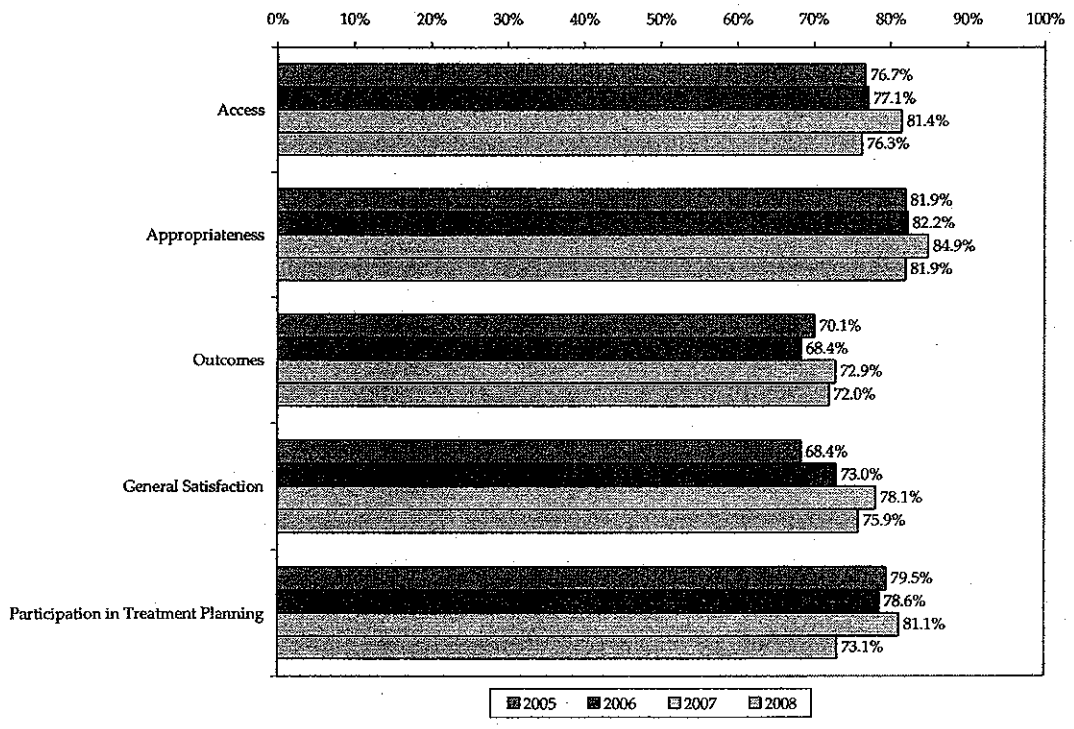
Responses to most of the questions were less positive in 2008 than in 2007. For ten questions there was a significantly less positive response in 2008 than in 2007 (see Table 3 in Appendix B for confidence intervals for each survey question):

- I like the services that I receive here.

- If I had other choices, I would still get services from this agency.
- I would recommend this agency to a friend or family member.
- Services were available at times that were good for me.
- I was able to get all the services I thought I needed.
- I was able to see a psychiatrist when I wanted to.
- I felt comfortable asking questions about my treatment and medication.
- I felt free to complain.
- Staff encouraged me to take responsibility for how I live my life.
- Staff were sensitive to my cultural background (race, religion, language, etc).

Figure 2 compares the responses from the 2005, 2006, 2007 and 2008 adult surveys for each of the five primary MHSIP domains. There was a decline in all five domains from the 2007 survey to the 2008 survey. The greatest declines were in the ***Access*** and ***Participation in Treatment Planning*** domains.

Figure 2
Percent of Respondents Agreeing – 2005 - 2008
By MHSIP Domain



A summary of the responses to the 28-item MHSIP survey for adults for 2008, plus the eight new questions related to Improved Functioning and Social Connectedness can be found in Table 4, Appendix B.

Youth Survey

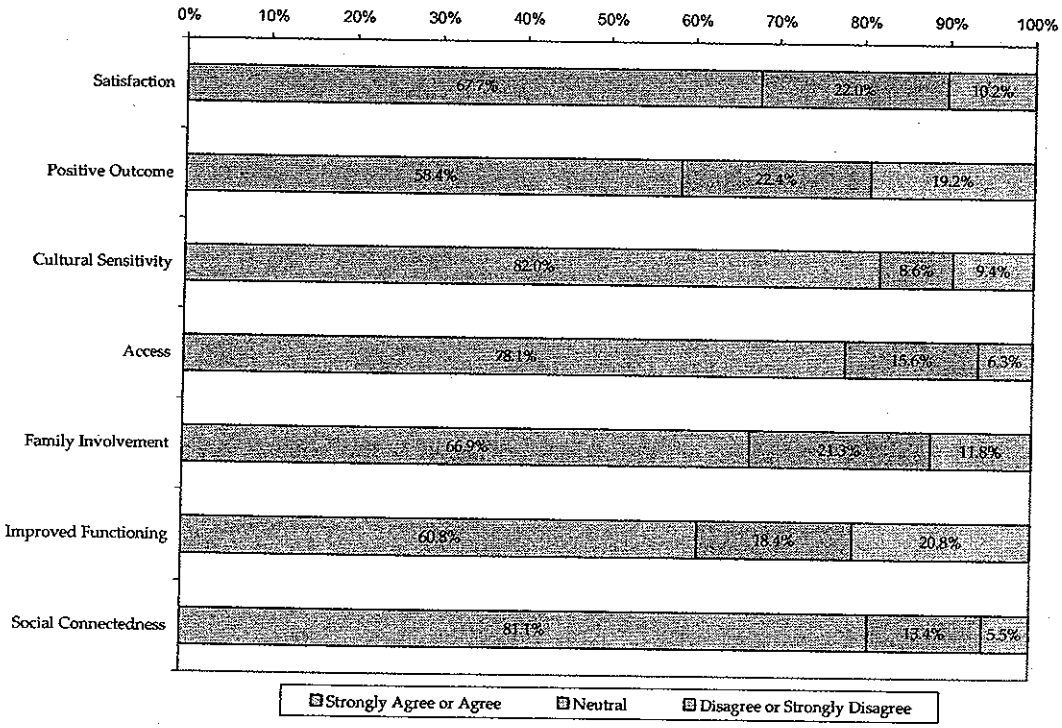
A total of 128 MHSIP youth surveys were completed in 2008, about half of the number completed in 2007. In most cases, a parent or guardian responded on behalf of the child receiving services. More surveys were completed for boys (60%) than for girls (40%). The youth's ages ranged from 4 years to 19 years, with an average age of 14.9 years. Most of the respondents were White, non Hispanic (72%); 28% were non-White or Hispanic.

For the Youth survey, responses for multiple questions were combined into the following five scales or "domains" (see Appendix A for the questions included in each): Satisfaction, Positive Outcome, Cultural Sensitivity, Access and Family Involvement.

Summary of Results – Youth Survey[2]

Most of the respondents (68%) indicated that they were satisfied with the services their child received (Figure 3). Ten percent (10%) were dissatisfied with the services their child received, and 22% were neutral. The most positive responses were in the **Cultural Sensitivity** domain - 82% of the respondents reported positively. Over half (58%) responded positively to the questions regarding **Positive Outcome.**

Figure 3
Statewide Summary – MHSIP Scales – Youth



[2] Because of the small sample size, and the large confidence interval (+/-9%), caution should be exercised in interpreting the results of the Youth Survey.

A summary of the responses to the MHSIP survey for youth for 2008 can be found in Table 5, Appendix B.

Table 1 shows a summary of sample size and response rates for the last five years. For the Adult survey the response rate had gone up each year until 2008, when it dropped to 31%. For the Youth survey, the response rate dropped from 47% in 2007 to 42% in 2008.

Table 1
Survey Sample Size and Response Rates – 2004-2008

Adult Survey	2004	2005	2006	2007	2008
a. How many Surveys were Attempted (sent out or calls initiated)?	4,412	4,821	3,592	5,198	5,980
b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	3,760	1,567	1,471	2,145	3,238
c. How many surveys were completed? (survey forms returned or calls completed)	657	749	795	1,173	1,019
d. What was your response rate? (number of Completed surveys divided by number of Contacts)	17%	48%	54%	55%	31%

Youth Survey	2004	2005	2006	2007	2008
a. How many Surveys were Attempted (sent out or calls initiated)?	592	768	1,567	1,037	784
b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	541	497	880	537	306
c How many surveys were completed? (survey forms returned or calls completed)	67	235	465	254	128
d. What was your response rate? (number of Completed surveys divided by number of Contacts)	12%	47%	53%	47%	42%

Below is a summary of the data reported by the Division to the Center for Mental Health Services for the Federal Community Mental Health Services Block Grant, Uniform Reporting System Table 11: Summary Profile of Client Evaluation of Care for 2006 through 2008. While improvement was seen in the responses to the Adult surveys between 2006 and 2007, consumer ratings were lower on the 2008 survey.

Table 2: Summary Profile of Client Evaluation of Care / Nebraska Consumer Survey Summary Results (URS Table 11)

Report Year (Year Survey was Conducted)	2006			2007			2008		
Adult Consumer Survey Results:	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent
1. Percent Reporting Positively About **Access.**	612	794	77.1%	925	1,137	81.4%	743	974	76.3%
2. Percent Reporting Positively About **Quality and Appropriateness** for Adults.	639	777	82.2%	948	1,117	84.9%	793	968	81.9%
3. Percent Reporting Positively About **Outcomes.**	532	778	68.4%	802	1,100	72.9%	688	955	72.0%
4. Percent of Adults Reporting on **Participation In Treatment Planning.**	547	749	73.0%	801	1,026	78.1%	638	873	73.1%
5. Percent of Adults Reporting Positively about **General Satisfaction** with Services.	625	795	78.6%	942	1,161	81.1%	767	1,010	75.9%
Child/Adolsecent Consumer Survey Results:	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent
1. Percent Reporting Positively About **Access.**	354	457	77.5%	197	253	77.9%	100	128	78.1%
2.Percent Reporting Positively about **General Satisfaction** for Children.	333	460	72.4%	167	253	66.0%	86	127	67.7%
3.Percent Reporting Positively about **Outcomes** for Children.	291	436	66.7%	132	251	52.6%	73	125	58.4%
4. Percent of Family Members Reporting on **Participation In Treatment Planning** for their Children.	308	448	68.8%	179	252	71.0%	85	127	66.9%
5. Percent of Family Members Reporting High **Cultural Sensitivity** of Staff. (Optional)	382	416	91.8%	195	252	77.4%	105	128	82.0%

Appendix A
Adult Survey Questions[1] and MHSIP Scales

The 28 items on the MHSIP Adult Survey were grouped into five scales. The grouping of the items into the five scales is consistent with the groupings required for the national Center for Mental Health Services' Uniform Reporting System. Below are the five scales and the survey questions included in each scale.

Access:

1. The location of services was convenient (parking, public transportation, distance, etc.).
2. Staff were willing to see me as often as I felt it was necessary.
3. Staff returned my call in 24 hours.
4. Services were available at times that were good for me.
5. I was able to get all the services I thought I needed.
6. I was able to see a psychiatrist when I wanted to.

Quality and Appropriateness:

1. I felt free to complain.
2. I was given information about my rights.
3. Staff encouraged me to take responsibility for how I live my life.
4. Staff told me what side effects to watch out for.
5. Staff respected my wishes about who is and who is not to be given information about my treatment.
6. Staff here believe that I can grow, change and recover.
7. Staff were sensitive to my cultural background (race, religion, language, etc.).
8. Staff helped me obtain the information I needed so that I could take charge of my managing my illness.
9. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)

Outcomes:

As a Direct Result of Services I Received:

1. I deal more effectively with daily problems.
2. I am better able to control my life.
3. I am better able to deal with crisis
4. I am getting along better with my family.
5. I do better in social situations.
6. I do better in school and/or work.
7. My housing situation has improved.
8. My symptoms are not bothering me as much.

---

[1] Possible Responses: Strongly Agree, Agree, Neutral, Disagree, and Strongly Disagree

Participation in Treatment Planning:

1. I felt comfortable asking questions about my treatment and medication.
2. I, not staff, decided my treatment goals.

General Satisfaction:

1. I like the services that I received here.
2. If I had other choices, I would still get services from this agency.
3. I would recommend this agency to a friend or family member.

Two additional scales (and the questions included in each) were included in the 2007 survey.

Functioning:

As a Direct Result of Services I Received:

1. My symptoms are not bothering me as much.
2. I do things that are more meaningful to me.
3. I am better able to take care of my needs.
4. I am better able to handle things when they go wrong.
5. I am better able to do the things that I want to do.

Social Connectedness:

1. I am happy with the friendships I have.
2. I have people with whom I can do enjoyable things.
3. I feel I belong to my community.
4. In a crisis, I would have the support I need from family or friends.

Youth Survey Questions and MHSIP Scales

The Youth survey questions and MHSIP scales were:

Satisfaction:

1. Overall I am satisfied with the services my child received.
2. The people helping my child stuck with us no matter what.
3. I felt my child had someone to talk to when he/she was troubled.
4. The services my child and/or family received were right for us.
5. My family got the help we wanted for my child.
6. My family got as much help as we needed for my child.

Positive Outcome:

As a result of the services my child and/or family received:

1. My child is better at handling daily life.

2. My child gets along better with family members.
3. My child gets along better with friends and other people.
4. My child is doing better in school and/or work.
5. My child is better able to cope when things go wrong.
6. I am satisfied with our family life right now.

Cultural Sensitivity:

1. Staff treated me with respect
2. Staff respected my family's religious/spiritual beliefs.
3. Staff spoke with me in a way that I understood.
4. Staff were sensitive to my cultural/ethnic background.

Access:

1. The location of services was convenient for us.
2. Services were available at times that were convenient for us.

Family Involvement:

1. I helped to choose my child's services.
2. I helped to choose my child's treatment goals.
3. I participated in my child's treatment.

Calculation of Survey Scale Scores

The following methodology was used to calculate the survey scale scores:

1. Respondents with more than 1/3rd of the items in the scale either missing or marked "not applicable" were excluded.
2. For those respondents remaining, an average score for all items in the scale was calculated
3. For each scale, the number of average scores from Step 2 that were 2.49 or lower were counted (scores that, when rounded, represent "Agree" or "Strongly Agree" responses).
4. For each scale, the count from Step 3 was divided by the count of "remaining" records from Step 1 to obtain a percent of positive responses.

For example:

1. Of the 1,019 Adult surveys, 45 had more than 1/3rd of the items in the **Access** scale either missing or marked "not applicable". Those 45 surveys were excluded from the calculation of the **Access** scale, leaving 974 surveys to be included in the calculation.
2. Average scale scores were calculated for each of the 974 surveys

3. Of the 974 remaining surveys:
   743 had average scores of 2.49 or lower (Agree/Strongly Agree)
   147 had average scores between 2.50 and 3.49 (Neutral)
   84 had average scores of 3.50 or higher (Disagree/Strongly Disagree)
4. The percent of "positive" responses for the **Access** scale was 743 (from Step 3) divided by 974 (from Step 1) = **76.3**

Scale Reliability

Cronbach's alpha was used to measure internal consistency among the items in each scale. With the exception of the Adult **Participation in Treatment Planning** scale and the Youth **Access** and **Family Involvement** scales, the results show consistency in measurement (reliability) among the items included in each scale.

Adult Scales (# of Items)	Alphas
Access (6)	.866
Quality and Appropriateness (9)	.933
Outcomes (8)	.940
Participation in Treatment Planning (2)	.704
General Satisfaction (3)	.914

Additional Adult Scales (# of Items)	Alphas
Improved Functioning (5)	.927
Social Connectedness (4)	.869

Youth Scales (# of Items)	Alphas
Satisfaction (6)	.915
Positive Outcome (6)	.922
Cultural Sensitivity (4)	.827
Access (2)	.774
Family Involvement (3)	.672

Appendix B

Table 1
2008 Adult Survey Scales by Race/Hispanic Origin

Scale	% Agree White Non-Hispanic	% Agree Non-White / Hispanic
Access	76.2%	79.0%
Appropriateness	82.7%	79.6%
Outcomes	72.0%	73.2%
General Satisfaction	75.3%	79.6%
Participation in Treatment Planning	73.0%	75.2%
Functioning	81.3%	78.6%
Social Connectedness	76.2%	78.4%

Table 2
2008 Adult Consumer Survey
Summary of Results by Race

	% Agree or Strongly Agree	
	White, non Hisp	Non-White or Hispanic
1. I like the services that I received here.	77.1%	78.9%
2. If I had other choices, I would still get services from this agency.	72.9%	76.0%
3. I would recommend this agency to a friend or family member.	78.6%	82.3%
4. The location of services was convenient (parking, public transportation, distance, etc.).	79.9%	83.1%
5. Staff were willing to see me as often as I felt it was necessary.	81.3%	84.8%
6. Staff returned my calls within 24 hours.	79.7%	79.9%
7. Services were available at times that were good for me.	83.2%	85.3%
8. I was able to get all the services I thought I needed.	76.7%	78.1%
9. I was able to see a psychiatrist when I wanted to.	69.1%	68.3%
10. Staff here believe that I can grow, change and recover.	86.5%	79.4%
11. I felt comfortable asking questions about my treatment and medication.	83.4%	86.0%
12. I felt free to complain.	77.9%	78.5%
13. I was given information about my rights.	87.3%	88.7%
14. Staff encouraged me to take responsibility for how I live my life.	85.6%	84.2%
15. Staff told me what side effects to watch out for.	75.6%	77.0%
16. Staff respected my wishes about who and who is not to be given information about my treatment.	88.9%	87.3%
17. I, not staff, decided my treatment goals.	74.4%	77.2%
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	87.5%	85.0%
19. Staff helped me obtain the information that I needed so that I could take charge of managing my illness.	81.1%	86.4%
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	78.5%	77.8%

As a result of the services received:		
21. I deal more effectively with daily problems.	74.9%	75.2%
22. I am better able to control my life.	76.1%	80.0%
23. I am better able to deal with crisis.	75.3%	80.4%
24. I am getting along better with my family.	75.0%	78.3%
25. I do better in social situations.	72.0%	78.7%
26. I do better in school and/or work.	70.1%	72.4%
27. My housing situation has improved.	65.0%	71.2%
28. My symptoms are not bothering me as much.	70.2%	74.6%
29. I do things that are more meaningful to me.	78.8%	82.1%
30. I am better able to take care of my needs.	78.7%	79.4%
31. I am better able to handle things when they go wrong.	76.6%	79.7%
32. I am better able to do the things that I want to do.	76.7%	78.6%
33. I am happy with the friendships I have.	86.0%	79.9%
34. I have people with whom I can do enjoyable things.	87.3%	86.1%
35. I feel I belong in my community.	77.4%	81.6%
36. In a crisis, I would have the support I need from family or friends.	89.1%	87.6%

*Shaded questions indicate statistically significant differences between the two groups.

Table 3
2007 and 2008 Adult Consumer Survey
Confidence Intervals

1 = Strongly Agree; 5 = Strongly Disagree	2007			2008		
	Mean	SD	95% Confidence Intervals	Mean	SD	95% Confidence Intervals
1. I like the services that I received here.	1.89	0.953	1.84 – 1.94	2.07	1.094	2.00 – 2.14
2. If I had other choices, I would still get services from this agency.	2.09	1.097	2.03 – 2.15	2.26	1.204	2.18 – 2.33
3. I would recommend this agency to a friend or family member.	1.93	1.023	1.87 – 1.99	2.07	1.136	2.00 – 2.14
4. The location of services was convenient (parking, public transportation, distance, etc.).	1.98	0.959	1.92 – 2.04	2.08	0.997	2.01 – 2.14
5. Staff were willing to see me as often as I felt it was necessary.	1.90	0.951	1.84 – 1.96	2.02	1.038	1.96 – 2.08
6. Staff returned my calls within 24 hours.	2.00	0.976	1.94 – 2.06	2.09	1.034	2.02 – 2.16
7. Services were available at times that were good for me.	1.85	0.869	1.80 – 1.91	2.00	0.961	1.94 – 2.06
8. I was able to get all the services I thought I needed.	2.05	1.055	1.99 – 2.11	2.19	1.120	2.12 – 2.26
9. I was able to see a psychiatrist when I wanted to.	2.17	1.085	2.10 – 2.24	2.34	1.151	2.26 – 2.42
10. Staff here believe that I can grow, change and recover.	1.80	0.821	1.75 – 1.85	1.90	0.940	1.84 – 1.96
11. I felt comfortable asking questions about my treatment and medication.	1.82	0.865	0.77 – 1.87	1.98	1.015	1.91 – 2.05
12. I felt free to complain.	2.01	0.998	1.95 – 2.07	2.16	1.098	2.08 – 2.22
13. I was given information about my rights.	1.83	0.820	1.78 – 1.88	1.92	0.890	1.86 – 1.98
14. Staff encouraged me to take responsibility for how I live my life.	1.77	0.744	1.73 – 1.81	1.89	0.918	1.83 – 1.95
15. Staff told me what side effects to watch out for.	2.11	1.036	2.05 – 2.17	2.15	1.086	2.08 – 2.22
16. Staff respected my wishes about who and who is not to be given information about my treatment.	1.77	0.830	1.72 – 1.82	1.82	0.869	1.77 – 1.87
17. I, not staff, decided my treatment goals.	2.07	0.974	2.01 – 2.13	2.18	1.046	2.11 – 2.25
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	1.80	0.774	1.76 – 1.84	1.91	0.862	1.85 – 1.97
19. Staff helped me obtain the information that I needed so that I could take charge of managing my illness.	1.96	0.923	1.91 – 2.01	2.02	0.990	1.96 – 2.08
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	2.12	1.010	2.06 – 2.18	2.09	1.034	2.02 – 2.16
As a result of the services received:						
21. I deal more effectively with daily problems.	2.05	0.967	1.99 – 2.11	2.17	1.031	2.11 – 2.23

22. I am better able to control my life.	2.04	0.940	1.98 – 2.10	2.11	0.999	2.05 – 2.17
23. I am better able to deal with crisis.	2.10	0.965	2.04 – 2.16	2.14	0.991	2.08 – 2.20
24. I am getting along better with my family.	2.06	0.949	2.00 – 2.12	2.10	0.994	2.04 – 2.16
25. I do better in social situations.	2.21	0.997	2.15 – 2.27	2.20	1.005	2.14 – 2.26
26. I do better in school and/or work.	2.22	1.038	2.15 – 2.29	2.23	0.999	2.16 – 2.30
27. My housing situation has improved.	2.37	1.062	2.30 – 2.44	2.31	1.066	2.24 – 2.38
28. My symptoms are not bothering me as much.	2.23	1.047	2.17 – 2.29	2.25	1.080	2.18 – 2.32
29. I do things that are more meaningful to me.	2.10	0.916	2.05 – 2.15	2.06	0.922	2.00 – 2.12
30. I am better able to take care of my needs.	2.08	0.925	2.03 – 2.13	2.08	0.940	2.02 – 2.14
31. I am better able to handle things when they go wrong.	2.13	0.942	2.07 – 2.19	2.14	0.954	2.08 – 2.20
32. I am better able to do the things that I want to do.	2.16	0.969	2.10 – 2.22	2.15	0.967	2.09 – 2.21
33. I am happy with the friendships I have.	1.99	0.902	1.94 – 2.04	1.96	0.871	1.91 – 2.01
34. I have people with whom I can do enjoyable things.	1.91	0.851	1.86 – 1.96	1.91	0.861	1.86 – 1.96
35. I feel I belong in my community.	2.16	1.008	2.10 – 2.22	2.10	0.952	2.04 – 2.16
36. In a crisis, I would have the support I need from family or friends.	1.86	0.894	1.81 – 1.91	1.83	0.871	1.78 – 1.88

* Shaded questions indicate statistically significant differences. For example, in Question 1 – "I like the services that I received here", respondents in 2008 responded significantly less positively than respondents in 2007.

Table 4
2008 Adult Consumer Survey
Summary of Results

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	% Agree/ Strongly Agree
1. I like the services that I received here.	335	442	106	68	55	77.2%
2. If I had other choices, I would still get services from this agency.	277	450	73	115	77	73.3%
3. I would recommend this agency to a friend or family member.	344	449	67	83	62	78.9%
4. The location of services was convenient (parking, public transportation, distance, etc.).	264	513	86	75	36	79.8%
5. Staff were willing to see me as often as I felt it was necessary.	322	488	65	73	43	81.7%
6. Staff returned my calls within 24 hours.	241	438	75	61	40	79.4%
7. Services were available at times that were good for me.	288	525	68	62	33	83.3%
8. I was able to get all the services I thought I needed.	265	503	78	88	66	76.8%
9. I was able to see a psychiatrist when I wanted to.	181	370	97	100	53	68.8%
10. Staff here believe that I can grow, change and recover.	343	476	75	34	34	85.1%
11. I felt comfortable asking questions about my treatment and medication.	308	456	59	52	41	83.4%
12. I felt free to complain.	271	488	79	79	59	77.8%
13. I was given information about my rights.	307	552	54	43	28	87.3%
14. Staff encouraged me to take responsibility for how I live my life.	348	478	69	51	23	85.2%
15. Staff told me what side effects to watch out for.	249	406	86	84	41	75.6%
16. Staff respected my wishes about who and who is not to be given information about my treatment.	363	489	55	33	23	88.5%
17. I, not staff, decided my treatment goals.	234	469	113	84	42	74.6%
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	287	513	74	25	26	86.5%
19. Staff helped me obtain the information that I needed so that I could take charge of managing my illness.	288	485	77	59	36	81.8%
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	263	448	90	74	37	78.0%

As a result of the services received:						
21. I deal more effectively with daily problems.	245	479	114	93	36	74.9%
22. I am better able to control my life.	264	479	111	91	27	76.4%
23. I am better able to deal with crisis.	243	485	119	87	28	75.7%
24. I am getting along better with my family.	265	437	135	67	29	75.2%
25. I do better in social situations.	223	464	133	98	27	72.7%
26. I do better in school and/or work.	181	385	139	78	24	70.1%
27. My housing situation has improved.	188	374	160	92	37	66.0%
28. My symptoms are not bothering me as much.	224	430	123	107	40	70.8%
29. I do things that are more meaningful to me.	247	505	112	66	21	79.1%
30. I am better able to take care of my needs.	245	502	111	68	24	78.6%
31. I am better able to handle things when they go wrong.	217	514	116	80	26	76.7%
32. I am better able to do the things that I want to do.	212	516	114	76	31	76.7%
33. I am happy with the friendships I have.	291	554	83	54	19	84.4%
34. I have people with whom I can do enjoyable things.	312	557	61	56	17	86.6%
35. I feel I belong in my community.	252	528	128	65	31	77.7%
36. In a crisis, I would have the support I need from family or friends.	371	521	47	46	21	88.7%

Table 5
2008 Youth Consumer Survey – Summary of Results

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Other	% Agree/ Strongly Agree
1. Overall I am satisfied with the services my child received.	36	62	20	5	4	1	77.2%
2. I helped to choose my child's services.	31	61	9	15	4	8	76.7%
3. I helped to choose my child's treatment goals.	27	69	7	16	3	6	78.7%
4. The people helping my child stuck with us no matter what.	35	66	9	11	5	2	80.2%
5. I felt my child had someone to talk to when he/she was troubled.	29	64	16	11	4	4	75.0%
6. I participated in my child's treatment.	41	62	11	8	4	2	81.7%
7. The services my child and/or family received were right for us.	27	62	15	14	6	4	71.8%
8. The location of services was convenient for us.	37	70	5	8	8	0	83.6%
9. Services were available at times that were convenient for us.	37	73	8	7	3	0	85.9%
10. My family got the help we wanted for my child.	22	68	19	9	8	2	71.4%
11. My family got as much help as we needed for my child.	21	63	17	16	10	1	66.1%
12. Staff treated me with respect.	49	69	4	3	1	2	93.7%
13. Staff respected my family's religious/spiritual beliefs.	44	61	9	0	0	14	92.1%
14. Staff spoke with me in a way that I understood.	44	73	7	1	2	1	92.1%
15. Staff were sensitive to my cultural/ethnic background.	36	69	9	0	0	14	92.1%
As a result of the services my child and/or family received:							
16. My child is better at handling daily life.	19	55	22	16	8	8	61.7%
17. My child gets along better with family members.	19	61	21	14	7	6	65.6%
18. My child gets along better with friends and other people.	16	69	18	11	6	8	70.8%
19. My child is doing better in school and/or work.	17	62	22	15	4	8	65.8%
20. My child is better able to cope when things go wrong.	15	63	19	19	8	4	62.9%
21. I am satisfied with our family life right now.	23	65	17	11	6	6	72.1%
22. My child is better able to do the things he/she wants to do.	19	69	15	13	6	6	72.1%
23. I know people who will listen and understand me when I need to talk.	24	79	9	7	7	2	81.7%

Skip Navigation

Mental Health Services

Finding Treatment for Mental Health Issues

Services are provided to Nebraska residents with mental illness and/or problems with addiction. Both children and adults are served. Ability to pay is not a factor; persons pay what they can afford.

Most of Nebraska's Behavioral Health services are managed directly by the six Regional Behavioral Health Authorities. These RBHA's are responsible to the counties they serve, and assure that vital services are available to persons in or near their home communities.

Activities Within the Division:

- Adult Behavioral Health Services
- Childrens Behavioral Health Services
- Critical Incident Stress Management Team
- Consumer Advocacy - Office of Consumer Affairs
- Mental Health Commitment Board Training
- Nebraska Mental Health Housing Information
- Nebraska Mental Health Needs Assessment

The RBHA's contract with local resources to provide public inpatient, outpatient, emergency and community services. The Division of Behavioral Health Services provides funding, oversight and technical assistance to the Regional Behavioral Health Authorities.

The Division of Behavioral Health Services also manages the Regional Centers that are located in Hastings, Norfolk and Lincoln. These Regional Centers provide longer-term care for persons committed by mental health boards or the courts. The Nebraska Behavioral Health Services Act mandates that care be focused in communities rather than hospitals. As a result, every effort is made to avoid lengthy hospitalizations and instead promote meaningful involvement in the consumers' communities of choice. The Regional Centers are monitored by DBHS to ensure high-quality, cost effective services that promote recovery in all phases of care.

Funding comes from a variety of resources, from the federal government to local counties. The Division of Behavioral Health assess for gaps in services and makes certain that funds are spent on prioritized needs. The Division also ensures that services are high-quality, cost-effective and accessible to those without health insurance or other funding.

Grants and Reports:

Mental Health Block Grant Fiscal Year 2009 Application 4,118 kb

Mental Health Block Grant Implementation Report FY 2008 1,412 kb
NE Final FY 2008 URS Tables (Part E of MH Block Grant) - Dec, 2008 147 kb
Mental Health Block Grant Fiscal Year 2008 Application 4,603 kb

Mental Health Block Grant Implementation Report FY 2007 726 kb
NE Final FY 2007 URS Tables (Part E of MH Block Grant) - **REVISED - Dec, 2008** 120 kb
NE Final FY 2007 URS Tables (Part E of MH Block Grant) - Dec, 2007 167 kb
Mental Health Block Grant Implementation Report FY 2006 1,258 kb

URS TABLES ON DHHS/BH WEB SITE

Projects for Assistance in Transition from Homelessness (PATH) FY 2008 691 kb
Projects for Assistance in Transition from Homelessness (PATH) FY 2007 365 kb
Projects for Assistance in Transition from Homelessness (PATH) FY 2006 363 kb

Mental Health Block Grant:

NE State Application FY 2009 Page - Public Comments on State Plan

Representing the Public and Consumer Advocacy

The Division of Behavioral Health works closely with many public agencies, service providers, and local governments. There are individual state-wide advisory committees for Mental Health, Substance Abuse and Problem Gambling. The State Advisory Committee on Mental Health Services' input, along with input from other agencies, providers and advisory boards is needed for the strategic planning of services, as well as identification and resolution of problems. This information is also given to legislators considering changes in Behavioral Health Law.

The DBH Office of Consumer Affairs can be directly accessed by consumers. Staff members are available to listen to concerns, investigate complaints and provide other advocacy services via the Helpline. Surveys are conducted to seek opinions on services and outcomes. They also help consumers by providing training, organizing advocacy activities and sharing information to affect public policy.

Documents in PDF format require the use of Adobe Acrobat Reader

Nebraska FY 2008 Uniform Reporting System (URS)

Prepared to Meet the Requirements of the

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

PART E: Uniform Data on Public Mental Health System

U.S. Department of Health & Human Services
Substance Abuse & Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)

By:
Nebraska Department of Health and Human Services
Division of Behavioral Health

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December 1, 2008

Analysis of the data for Tables 2A, 2B, 3, 4, 4a, 5A, 5B, 6, 12, 14A, 14B, 15, portions of 16, 17, 20A, 20B, and 21 are completed by the Epidemiology Department in the College of Public Health at the University of Nebraska Medical Center (UNMC) under contract with the Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health. The following comments apply to these tables:

- Over the last year, the Nebraska Division of Behavioral Health and the Administrative Services Only Managed Care Contractor, Magellan Health Services, have been working on cleaning up the data in the area of community Behavioral health.

- Specifically, the discharge date fields have started to be corrected. As a result, there has been improvement in discharging consumers who were no longer receiving services. This has happened over a wide variety of services.
- As a result, it appears DHHS/Magellan have been making strides at fixing the missing discharge dates for certain areas. Specifically, consumers who were counted in the past (because one could not tell if the individual had been discharged or not), are no longer being counted.
- However, there remains a fair number of records from 2003-2005 without what appears to be reasonable discharge dates. The problem here is, while being older, it does not mean the record can be discounted, since from the data one can not determine if th

- As DHHS/Magellan continues to fix missing discharge dates, the numbers for past years will most likely continue to drop. However, the overall trend should continue to increase from year to year and should still be reflected in the data.
- the same methodology developed by UNMC was used for both FY2007 and FY2008 counts. As a result, selected FY2007 data tables are being resubmitted (Tables 2A, 2B, 3, 4, 4a, 5A, 5B, 6, 12, 14A, 14B, 15, selected data from 16, 17, 20A, 20B, and 21).

The full Table names prepared by UNMC are:

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity
Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity
Table 3. Profile of Persons served in the community mental health setting,

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please report the data under the categories listed - "Total" are calculated automatically.

Table 2.														
Report Year:	2008													
State Identifier:	NE													
	Total				American Indian or Alaska Native			Asian			Black or African American			
	Female	Male	Not Available	Total	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	
0-12 Years	[illegible]	[illegible]	[illegible]	[illegible]	31	40		5	11		73	120		
13-17 years	[illegible]	[illegible]	[illegible]	[illegible]	23	51		7	10		50	104		
18-20 years	[illegible]	[illegible]	[illegible]	[illegible]	21	26		9	8		50	75		
21-64 years	[illegible]	[illegible]	[illegible]	[illegible]	432	439		72	79		984	1,422		
65-74 years	[illegible]	[illegible]	[illegible]	[illegible]	2	9		2	0		11	12		
75+ years	[illegible]	[illegible]	[illegible]	[illegible]	2	3		3	0		1	1		
Not Available	[illegible]	[illegible]	[illegible]	[illegible]										
Total	16,839	20,072	[illegible]	36,911	[illegible]	568	0	98	108	0	1,169	1,734	0	

Are these numbers unduplicated? ☑ Unduplicated ☐ Duplicated: between Hospitals and Community ☐ Duplicated Among Community Programs ☐ Duplicated between children and adults ☐ Other: describe:

Comments on Data (for Age):	The age was calculated as follows: [(July 1, 2007– (Consumer Birth Date)] / 365.25]
Comments on Data (for Gender):	If multiple genders listed, the most frequent gender was reported.
Comments on Data (for Race/Ethnicity):	For race listed as "Other", reported in "More than one race reported".
Comments on Data (Overall):	See General Comments.

NE URS 2007
AS SUBMITTED DEC 1, 2007

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please report the data under the categories listed - "Totals" are calculated automatically.

Table 2.														
Report Year:	2007													
State Identifier:	NE													
	Total				American Indian or Alaska Native			Asian			Black or African American			
	Female	Male	Not Available	Total	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	
0-12 Years	716	1209	0	1925	25	47		6	11		83	128		
13-17 years	917	1256	0	2173	35	51		7	9		48	96		
18-20 years	996	1693	0	2689	26	37		9	12		60	75		
21-64 years	13903	15700	0	29603	399	456		64	87		912	1377		
65-74 years	65	232	0	297	2	10		1			12	10		
75+ years	111	196	0	307	1	3		3						
Not Available	0	0	0	0										
Total	16602	20886	0	37488	488	604	0	90	119	0	1115	1686	0	

Are these numbers unduplicated? ☑ Unduplicated ☐ Duplicated: between Hospitals and Community ☐ Duplicated Among Community Programs ☐ Duplicated between children and adults ☐ Other: describe:

Comments on Data (for Age):	The age was calculated as follows: [(July 1, 2006– (Consumer Birth Date)] / 365.25]
Comments on Data (for Gender):	If multiple genders listed, the most frequent gender was reported.
Comments on Data (for Race/Ethnicity):	For race listed as "Other", reported in "More than one race reported".
Comments on Data (Overall):	See General Comments.

NE URS 2007
REVISED DEC 1, 2008

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please report the data under the categories listed - "Total" are calculated automatically.

Table 2.													
Report Year:	2007												
State Identifier:	NE												
	Total				American Indian or Alaska Native			Asian			Black or African American		
	Female	Male	Not Available	Total	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0-12 Years	[redacted]	[redacted]	[redacted]	[redacted]	27	45		6	10		86	126	
13-17 years	[redacted]	[redacted]	[redacted]	[redacted]	32	50		7	9		48	97	
18-20 years	[redacted]	[redacted]	[redacted]	[redacted]	23	30		9	6		56	70	
21-64 years	[redacted]	[redacted]	[redacted]	[redacted]	368	384		67	77		891	1,283	
65-74 years	[redacted]	[redacted]	[redacted]	[redacted]	2	9		5	0		12	9	
75+ years	[redacted]	[redacted]	[redacted]	[redacted]	1	3		3	0		0	0	
Not Available	[redacted]	[redacted]	[redacted]	[redacted]									
Total	[redacted]	[redacted]	[redacted]	[redacted]	453	521	0	97	102	0	1,093	1,585	0

Are these numbers unduplicated? ☑ Unduplicated ☐ Duplicated: between Hospitals and Community ☐ Duplicated Among Community Programs ☐ Duplicated between children and adults ☐ Other: describe:

Comments on Data (for Age):	The age was calculated as follows: [(July 1, 2006– (Consumer Birth Date)] / 365.25]
Comments on Data (for Gender):	If multiple genders listed, the most frequent gender was reported.
Comments on Data (for Race/Ethnicity):	For race listed as "Other", reported in "More than one race reported".
Comments on Data (Overall):	See General Comments.